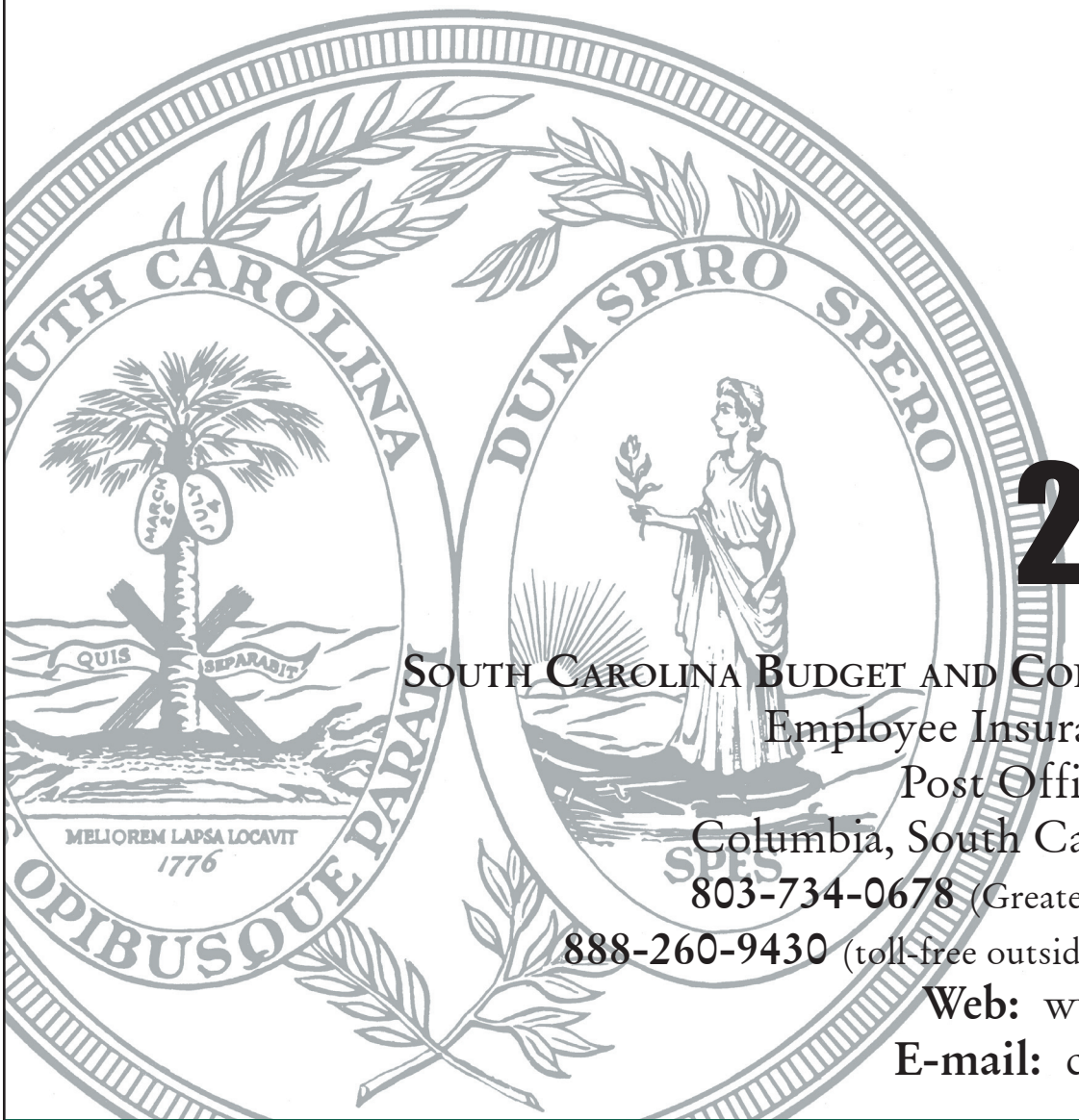
Insurance Orientation Handbook



2006

SOUTH CAROLINA BUDGET AND CONTROL BOARD
Employee Insurance Program
Post Office Box 11661
Columbia, South Carolina 29211
803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside Columbia area)
Web: www.eip.sc.gov
E-mail: cs@eip.sc.gov

Contact Information

AETNA

Long Term Care

Long Term Care, RT 52
151 Farmington Avenue
Hartford, CT 06156
Hotline: 800-537-8521
Fax: 860-952-2024
www.aetna.com/group/southcarolina

APS HEALTHCARE INC.

SHP Mental Health and Substance Abuse

Claims, State of SC
P.O. Box 1307
Rockville, MD 20849
Customer Service: 800-221-8699
Tobacco Treatment: 866-784-8454
Fax: 888-897-8931
www.apshealthcare.com
(password=statesc)

ASI

TRICARE Supplement

P.O. Box 2510
Rockville , MD 20847
Customer Service: 800-638-2610, ext. 255
Fax: 301-816-1125
www.corporatetricaresupp.com
www.tricare.osd.mil

BLUECROSS BLUESHIELD OF SOUTH CAROLINA

SHP Standard Plan, Savings Plan, Medicare Supplemental Plan

P.O. Box 100605
Columbia, SC 29260-0605
Customer Service Center:
800-868-2520
803-736-1576
Fax: 803-699-7675

Medi-Call

BlueCross BlueShield of SC
AF 330
I-20 Alpine Road
Columbia, SC 29219
800-925-9724
803-699-3337
Fax: 803-264-0183

BlueCard

800-810-BLUE (2583)

State Dental Plan, Dental Plus

BlueCross BlueShield of SC
P.O. Box 100300
Columbia, SC 29202-3300
Customer Service: 888-214-6230
Fax: 803-264-7739
www.southcarolinablues.com

CIGNA HEALTHCARE HMO

P.O. Box 5200
Scranton, PA 18505-5200
Member Services: 800-244-6224
www.cigna.com

BLUECHOICE HEALTHPLAN OF SC

P.O. Box 6170
AX-435
Columbia, SC 29260-6170
Member Services:
800-868-2528
803-786-8476
www.bluechoicesc.com

EMPLOYEE INSURANCE PROGRAM

Street Address:
1201 Main Street, Suite 300
Columbia, SC 29201
Mailing Address:
P.O. Box 11661
Columbia, SC 29211-1661
Customer Service:
803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside Columbia area)
Retiree Billing: 803-734-1696
Fax: 803-737-0825
www.eip.sc.gov

FRINGE BENEFITS MANAGEMENT COMPANY

MoneyPlu$

P.O. Box 1878
Tallahassee, FL 32302-1878
3101 Sessions Road
Tallahassee, FL 32303
Customer Service: 800-342-8017
Automated Information: 800-865-FBMC (3262)
Claims Fax: 850-425-4608
Other Fax: 850-425-6220
www.fbmc-benefits.com

(Continued on inside back cover)

Introduction

Your insurance benefits are important to you and to your family. Consequently, helping you understand those benefits is important to us. This handbook is for new employees of employers that participate in the state insurance program and employees of employers that have just joined the state insurance program. It will guide you through the enrollment process and will give you information that will help you make the insurance choices that best suit your needs.

Certain benefit options are based on your annual salary, so you may need to contact your personnel office to obtain this information. Bring this handbook and any information and documentation you may need, including your annual salary, to your orientation meeting.

Please take the time to review this book and discuss your benefits choices with family members before attending your orientation meeting. All insurance benefits programs available to you will be explained in detail during orientation. At the end of the meeting you will need to make your benefits choices.

The 2006 monthly premiums for the different insurance plans are listed, beginning on page 30. If you are paid twice each month, half of your monthly premiums will be deducted from each check. If you are interested in health maintenance organization (HMO) coverage, you may contact the HMO for benefits information. Telephone numbers for each of the HMOs are on the inside cover of this guide.

Please note: This booklet is only a brief summary of the insurance benefits that are now available to you. For more detailed information about your coverage and how to use it, please refer to the materials offered by the HMOs, the *Tax-Favored Accounts Guide* from FBMC and the *2006 Insurance Benefits Guide*. You may also contact your benefits office or visit the Employee Insurance Program Web site at www.eip.sc.gov.

This booklet contains an abbreviated description of insurance benefits. *The Plan of Benefits Document* contains a complete descriptions of the health and dental plans. Its terms and conditions govern all health benefits offered by the state. If you would like to review this document, contact your benefits administrator or the Employee Insurance Program.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Eligibility Rules

These are the rules used to determine whether employees and their dependents are eligible for insurance coverage. There are specific eligibility rules for retirees. *See page 3 for more information on retiree eligibility.*

EMPLOYEES

An eligible active employee:
- Is employed by the state, a school district or a participating local subdivision
- Works in a permanent full-time position as defined in the plan and
- Receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipal councils, who also participate in the S.C. Retirement Systems (SCRS), are considered employees for insurance purposes. If you work for more than one participating employer, please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu$ and vision care benefits.

If you are an eligible employee or retiree of a participating employer in South Carolina, you can enroll in a health plan or an HMO and the dental plan within 31 days of the date you are hired or the date you retire.

DEPENDENTS

SPOUSE

You may cover either your lawful spouse or former spouse (if you are required to do so by a divorce decree or court order), but not both your spouse and former spouse. If you are required to provide health insurance only for your former spouse, you may cover your current spouse under other policies, including dental, long term care and dependent life.
- If you are under a court order to carry your ex-spouse after a divorce, bring a complete copy of the divorce decree to your orientation meeting.
- If you are in a common-law marriage, bring proof or a notarized statement that you are in a common-law marriage.
- If your spouse is a covered employee or retiree of a participating employer and is carrying you on his insurance, you must be removed from his coverage and enrolled with your own employer.
- You must provide your spouse's date of birth and Social Security Number.

CHILDREN

You may cover any of your unmarried children who are under age 19 and are principally dependent (more than 50 percent) upon you for maintenance and support. This includes a natural or adopted child, stepchild, foster child (a child placed with you by an authorized placement agency and for whom you care as you would your own child) or a child for whom you have legal custody and who resides in the home in a normal parent/child relationship, or for whom you provide support and maintenance because of a court order.
- If you are required to cover a dependent child after a divorce, please bring a complete copy of the divorce decree to your orientation meeting.

Dependents who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your BA or EIP as soon as possible but no later than within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

- If you provide foster care or are in the process of adopting, please bring documentation of custody if you wish to provide coverage.
- If both you and your spouse are employees or retirees of a participating employer, only one of you may cover your eligible dependents.
- Bring a completed Dependent with Same or Different Last Name form (available from your benefits office or the Employee Insurance Program (EIP) Web site at www.eip.sc.gov) for any dependent child who lives with you in a parent/child relationship but has a different last name.
- You must provide dates of birth and Social Security Numbers for your dependent children.

You may cover an unmarried child, age 19 through 24, who is a **full-time student** as defined by the institution and who is principally dependent (more than 50 percent) upon you for maintenance and support.

- You must bring the appropriate documentation (a letter from the school's registrar) to your orientation meeting.
- You must also provide dates of birth and Social Security Numbers for your dependent children.

You may cover an unmarried child who is **incapable of self-sustaining employment** because of mental illness or physical handicap and who is primarily dependent (more than 50 percent) upon you for maintenance and support. The child must have been incapacitated while an eligible dependent. Coverage for your incapacitated dependent child is contingent upon approval from EIP.

- Please bring a completed Incapacitated Child Certification Form (available from your benefits office or the EIP Web site at www.eip.sc.gov) to your orientation meeting.
- You must provide the date of birth and the Social Security number for your dependent child.

RETIREES

Retirees **from employers that participate in the state insurance program** are eligible for insurance coverage if they meet one or more of these requirements and retire:

- Due to years of service with a participating state insurance employer
- Due to age
- On approved disability through the S.C. Retirement Systems (SCRS)
- On approved Basic Long Term Disability and/or Supplemental Long Term Disability

To qualify for the retiree group insurance program as either a non-funded or a funded retiree, your last five years of employment must be served continuously and consecutively, with an employer that participates in the Employee Insurance Program, and in a full-time, permanent position. Additional service credit for unused sick leave may not be used to qualify for the retiree group insurance program.

Funded and non-funded retirees please note: Whether you are a funded or a non-funded retiree, non-qualified, federal, military, out-of-state employment, sick leave and service with employers that do not participate in the state insurance program does not count toward your 5-, 10- or 20-year eligibility requirement.

If you and/or your dependents are not covered at the time of your retirement, you may enroll *within 31 days* of your retirement date or *within 31 days* of a special eligibility situation (pages 24-25). You will then be subject to pre-existing condition limitations for 12 months. A Certificate of Creditable Coverage may be used to reduce the limitation period. See page 7 for more information.

FUNDED VS. NON-FUNDED RETIREE INSURANCE PREMIUMS

If you are a state or school district retiree and qualify for funded benefits, the state will contribute to your premiums to the same extent it contributes to the premiums of an active employee. Local subdivisions may or may not pay a portion of the cost of their retirees' group insurance premium. Each subdivision develops its own guidelines for funding retiree insurance premiums.
A local subdivision is a public employer in South Carolina that falls within one of the categories estab-

lished by Section 1-11-720 of the 1976 S.C. Code of Laws. Local subdivisions include counties, municipalities, regional tourism promotion commissions, county disability and special needs boards, regional councils of government, regional transportation authorities and alcohol and other drug abuse agencies. **If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.**

OPTIONAL RETIREMENT PROGRAM (ORP)

State Optional Retirement Program retirees must follow the same insurance eligibility guidelines as SCRS participants.

FUNDED RETIREES

Funded retirees are those whose employer contributes to their retiree insurance premiums and whose last five years of employment were in a permanent, full-time position with an employer that participates in the state insurance program. They must meet one of these guidelines:

- Employees who are eligible to retire and have 10 or more years of earned S.C. Retirement Systems (SCRS) service credit with an employer that participates in the state insurance program.
- Employees who leave employment before they are eligible to retire but who have 20 or more years of earned SCRS service credit with an employer that participates in the state insurance program. However, they are not eligible for insurance coverage until they are eligible to receive a retirement check at age 60.
- **An exception:** Employees who left employment before 1990 and who were not of retirement age, but who had 18 years of earned SCRS service credit with an employer that participates in the state insurance program, returned to work with a state-covered group, enrolled in a state health and dental plan, and worked for at least two consecutive years in a full-time, permanent position.

NON-FUNDED RETIREES

Non-funded retirees are those who do not quality for funded benefits (see previous rules) and who must pay the full premium, which includes the retiree share plus the state contribution. It may also include an administrative fee. To qualify, a retiree's last five years of employment must have been continuous and consecutive in a permanent, full-time position with an employer that participates in the state insurance program. Non-funded retirees include:

- Employees who retire at age 55 with at least 25 years of retirement service credit (including at least 10 years of earned service credit with an employer that participates in the state insurance program). You must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. Although sick leave may increase service credit under SCRS, retirees must pay the entire premium until age 60 or until they reach the date they would have had 28 years of service credit if they had continued working. At the end of this period, you will be eligible for funded retiree rates. This rule does not apply to Police Officers Retirement System, General Assembly Retirement System and Judicial Retirement System participants. If you are in one of these groups, contact your benefits office for additional information. If you are retiring from a local subdivision, contact your benefits administrator for premium information.
- Employees who are eligible to retire and have at least five but fewer than 10 years of earned SCRS service credit with a participating state insurance program employer.
- General Assembly members who leave employment before they are eligible to retire and have eight years of General Assembly Retirement System service credit.
- Former municipal and county council members who served on council for at least 12 years and were covered under the state's plan when they left the council. It is up to the county or municipal council to decide whether or not to allow former members to have this coverage.

TERI

A Teacher and Employee Retention Incentive program (TERI) participant is retired for retirement benefit purposes only. For insurance benefits purposes, a program participant is considered an active employee, retaining all other rights and benefits of an active employee. Therefore, if you are a TERI program participant in a permanent, full-time position, your insurance benefits as an active employee continue until your TERI period ends or you become ineligible as an active employee. When your active insur-

ance benefits end, you should file for continuation as a retiree (if eligible) within 31 days of your date of retirement. Your service as a TERI participant in a full-time, permanent position with a participating insurance program employer may be applied toward retiree insurance eligibility.

Any covered subscriber who loses coverage and does not meet any of these rules may still be eligible for continuation coverage under COBRA.

SURVIVORS

If you are a covered spouse or child of a deceased employee, or funded retiree, of a state agency or a school district, your health insurance premium will be waived for one year after the death of the employee or retiree. Local subdivisions may elect to, but are not required to, waive the health premiums of survivors of retirees. After the first year, you must pay the full premium to continue coverage. Dental premiums are never waived.

- If the deceased was a covered employee who was killed in the line of duty, health insurance premiums will be waived for one year for the covered surviving spouse and dependent children. After the one-year waiver, eligible survivors may continue coverage at the employer-funded rate. If the employer is a local subdivision, survivors should contact the employer for premium information.
- A surviving spouse who remarries becomes ineligible to continue coverage.
- A dependent child can continue coverage until age 19, or until age 25 if he is a full-time student. (Documentation is required.) A dependent child, who marries, obtains employment with benefits or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support, becomes ineligible to continue coverage.
- An incapacitated child may continue coverage beyond the age requirements. (Medical documentation is required.) He becomes ineligible for insurance coverage if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support.

Enrollment

To enroll in an insurance program, you must complete a Notice of Election (NOE) form. To cover your eligible dependents, each dependent must be listed on the NOE form (section #6). The completed NOE must be submitted to your personnel office within 31 days of your date of hire.

You must complete separate applications to enroll in MoneyPlu$ accounts and Long Term Care.

A sample NOE is included on pages 27-28. It may be helpful for you to practice completing the form before your orientation meeting. Doing this will assist you in gathering the information you need for your orientation meeting.

Do not forget to include your dependent's Social Security Number! If you have a dependent, age 19-24, who is a full-time student, you must bring verification of his student status on letterhead from the registrar of the institution he attends.

After you enroll, you should check your payroll stub to make sure your payroll deductions agree with the benefits and levels you selected. Your coverage selections will continue from one year to the next, with the exception of MoneyPlu$ accounts (see pages 19-20), as long as you are an eligible employee—unless you elect changes during an enrollment period or after a special eligibility situation.

Your benefits administrator will let you know if he will be enrolling you through an electronic enrollment system, which is available to benefits administrators who have signed up for this feature offered through EIP.

WHEN COVERAGE BEGINS

Your coverage begins on the first day of the month coinciding with, or after, the date you begin employment and are actively at work. Coverage for your enrolled dependents begins when your coverage becomes effective.

COORDINATION OF BENEFITS

Some families, particularly those in which both the husband and wife work outside the home, are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you probably will pay premiums for both plans. Weigh the advantages and disadvantages carefully before you purchase extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Plan administrators, such as BlueCross BlueShield of South Carolina or your HMO, coordinate benefits so that you get the maximum reimbursement allowed. That amount will never be more than 100 percent of your covered medical, dental or prescription drug expenses.

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is primary.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

COORDINATION OF BENEFITS WITH MEDICARE

If you are eligible for Medicare and are enrolled as an active employee through the Employee Insurance Program (the State Health Plan, BlueChoice HealthPlan, CIGNA HMO, or MUSC Options), your health coverage through EIP is primary. (Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.) When you enroll as a retiree, Medicare Parts A and B become your primary coverage. It is important to enroll in Medicare Part B when you become eligible for Medicare, since your health insurance will then coordinate with Part B benefits. In the case of Medicare Part D, the drug coverage you have through the State Health Plan or through your health maintenance organization is as good as, or better than, coverage offered through Part D. Therefore, most people should not sign up for Part D.

There is an exception: If you are covered by Medicare, you may be eligible for higher benefits under Part D if your resources are less than $11,500 for individuals and less than $23,000 for married couples. Under these conditions, Part D could lower your out-of-pocket drug costs. If you feel you may qualify for this additional assistance, contact Social Security at 800-772-1213 or at 800-325-0778 (TTY), for the hearing impaired.

IMPORTANT MEDICARE NOTE:

If you or one of your dependents become eligible for Medicare, you must notify EIP within 31 days of Medicare eligibility. **If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance,** when EIP discovers you are eligible for Medicare, EIP will:

- **Immediately begin paying benefits as if you were enrolled in Medicare.**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

LATE ENTRANT

A late entrant is a full-time employee, retiree or dependent who did not enroll within 31 days of his first date of eligibility but who later enrolls during open enrollment. A late entrant is subject to a pre-existing condition exclusion for 18 months after coverage begins.

PRE-EXISTING CONDITION

A pre-existing condition limitation period applies to the health plans (both the State Health Plan and the health maintenance organizations) and to the Basic and Supplemental Long Term Disability plans.

Health Plans

A pre-existing condition is any medical condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed healthcare provider or practitioner in the six months before the covered person's enrollment date under the plan. Benefits for a pre-existing condition are payable only for treatment rendered 12 months (18 months for a late entrant) after the enrollment date of a covered person. If you have been insured previously, you may reduce the pre-existing condition period by providing certification of prior health insurance coverage if the break in coverage did not exceed 62 days.

Long Term Disability Plans

There also are pre-existing condition limitations for LTD and SLTD. More information is available in the *Insurance Benefits Guide.*

Certificate of Creditable Coverage

Creditable coverage is prior coverage under a group health plan or insurance coverage or health benefits provided as described or defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proof of creditable coverage may be used to reduce a pre-existing condition limitation period if the prior coverage was continuous (any break in coverage did not exceed 62 days). If you and/or your dependents are enrolling in a state health plan for the first time, you are responsible for obtaining and submitting a certificate of creditable coverage with your enrollment form.

COBRA

COBRA is short for the *Consolidated Omnibus Budget Reconciliation Act*. It requires that continuation of group insurance coverage be offered to you and to your covered dependents if you are no longer eligible for coverage under this Plan.

You can continue your coverage for a limited time under COBRA if you and/or your covered dependents lose coverage because:

- Your working hours are reduced from full-time to part-time
- You voluntarily quit work, are laid off or are fired (unless the firing is due to gross misconduct)
- You are a separated or divorced spouse or
- You are no longer eligible as a dependent child

If the event is not reported by you or your dependent within the 60-day limit, COBRA coverage will not be offered.
Rules and regulations governing continuation of coverage under COBRA are described in your *Insurance Benefits Guide*. If you need additional information, you may contact EIP. If you are enrolled through a local subdivision, contact your benefits office.

Choosing a Health Plan

ENROLLMENT PERIODS

There are two types of enrollment periods: **annual enrollment** and **open enrollment**. Annual enrollment, held every year in October, is a period during which eligible employees and retirees may change health plans. No other changes are allowed. Retirees may not change to or from the Medicare Supplemental Plan. Open enrollment, held in October of odd-numbered years, is a period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan and/or dental plan without regard to any special eligibility situations. Retirees may change to and from the Medicare Supplemental Plan.

Enrollment changes made during these periods become effective January 1.

WHAT ARE MY CHOICES?

THE STATE HEALTH PLAN (SHP)

The SHP is a Preferred Provider Organization (PPO) that has arrangements with doctors, hospitals and other providers who have agreed to accept the Plan's allowable charges for covered medical services as payment in full and will not *balance bill* you. (Balance billing is when a provider charges more for medical services than the Plan allows.) Participating providers also file the claims for you. An SHP subscriber is free to use any physician or hospital he or she chooses, with the exceptions of behavioral health providers and pharmacies. However, a subscriber will receive the highest level of benefits if her/his care is provided by an SHP network participant. The SHP has three options: the *Standard Plan*, the *Savings Plan* and the *Medicare Supplemental Plan*. The Standard and Savings plans are offered statewide to active employees, COBRA subscribers, survivors and retirees. (Retired subscribers who are eligible for Medicare may not enroll in the Savings Plan.) The Medicare Supplemental Plan is offered statewide to retirees and survivors who are enrolled in Medicare.

TRADITIONAL HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

An HMO is a managed care plan that requires subscribers to see only providers within its network. If you receive care outside the network, the HMO will not pay benefits for these services unless the care is pre-authorized or you have a life- or limb-threatening illness or injury. You are required to choose a pri-

mary care physician (PCP) who coordinates all aspects of your healthcare. To receive benefits, you must receive a referral from your PCP before you see a specialist. Active employees must live or work in an HMO service area to enroll in its plan. Retirees, COBRA subscribers and survivors must live in an HMO service area to enroll in its plan. Choices are:

- **BlueChoice HealthPlan—**offered **statewide.**
- **CIGNA HMO**—offered in all counties **except Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda**.

HMO WITH POINT OF SERVICE (POS) OPTION

A POS plan is an HMO that allows you to go to providers inside or outside its network. To receive the highest level of benefits, care must be obtained within the HMO network and be authorized by the HMO. When you use out-of-network services, you are likely to have much higher out-of-pocket expenses in the form of deductibles and copayments. The only HMO with a POS option offered is **MUSC Options**, which is available in **Berkeley, Charleston, Colleton and Dorchester** counties. Active employees must live or work in this service area to enroll in the plan. Retirees, COBRA subscribers and survivors must live in the service area to enroll in the plan.

TRICARE SUPPLEMENT

TRICARE is the Department of Defense's health insurance program for the military community. It consists of TRICARE Prime, an HMO; TRICARE Extra, a preferred-provider option; TRICARE Standard, the new name for CHAMPUS; and TRICARE Reserve Select, a premium-based program for reservists who served at least 90 days of active duty on or after September 11, 2001.

The TRICARE Supplement Plan is secondary coverage to TRICARE. It pays the employee's share of his covered medical expenses under the TRICARE Standard and Extra options. Eligible participants have almost 100 percent coverage. Underwritten by The Hartford Life Insurance Company, the plan is administered by the Association & Society Insurance Corporation (ASI).

The TRICARE Supplement is designed for TRICARE-eligible employees and for covered employers' retirees until they become eligible for TRICARE for Life, a Medicare supplement. It is an alternative to the State Health Plan and the health maintenance organizations. For more information on the TRICARE Supplement, go to the EIP's Web site at www.eip.sc.gov, visit www.scemployee29.absmil.net or call ASI at 800-638-2610, ext. 255.

The TRICARE Supplement is available to:

- Family members and survivors of active-duty military personnel
- Military retirees and their spouses or surviving spouses under age 65 or surviving spouses and their unmarried, dependent children under age 21, or under age 23 if full-time students
- Retired reservists, retired Guardsmen and their families, if the reservist or Guardsman is between the ages of 60 and 65 and has at least 20 creditable years of military service
- Spouses and unmarried dependent children of reservists, who are ordered to active duty for more than 30 days (they are covered only during the reservist's active duty), or of a reservist who died while on active duty
- Former spouses of active-duty or retired military personnel who were married to a service member or former service member who had at least 20 years of creditable service when a divorce or annulment occurred
- Spouses and unmarried eligible dependent children who are eligible for CHAMPVA
- Retired state employees who are under the age of 65 and eligible for TRICARE
- Reservists enrolled in TRICARE Reserve Select and their enrolled dependents.

Eligible subscribers **must** be registered with the Defense Enrollment Eligibility Reporting System (DEERS) and **must not** be eligible for Medicare. You must also drop your SHP or HMO coverage to enroll in the TRICARE Supplement plan. For more information, visit www.scemployee.absmil.net or call 800-638-2610, extension 255 (toll-free).
When an active employee or retiree becomes eligible for Medicare, TRICARE Supplement coverage

ends for him and for all covered dependents. Covered dependents who are not eligible for Medicare must begin paying TRICARE Supplement premiums through ASI. If a dependent becomes eligible for Medicare before the active employee, survivor or retiree, the dependent is no longer eligible for the state TRICARE Supplement.

MAKING A DECISION

Choosing a health plan requires thought and planning. Costs, services provided, benefits offered and provider networks are all major factors to consider when making a health plan decision. Although no plan will cover all of your medical costs, there are plans that are better suited than others for you and your family's health needs.

You cannot predict exactly what your healthcare needs will be for the coming year, but you can anticipate to some extent what services you and your family might need. By taking the time to decide what benefits and services are important to you and your family and by comparing the available plans, you will be able to choose a health plan that is right for you.

WHAT BENEFITS ARE OFFERED?

Although most plans provide basic health coverage, the details are what count. When choosing a plan, you may want to find out how it covers:

- Specialist care
- Emergency room visits and hospitalizations
- Prescription drugs
- Mental health and substance abuse services
- Obstetrical-gynecological care and well child care visits
- Physical exams
- Health screenings and other preventive care
- Nursing home, home health and hospice care
- Physical therapy and other rehabilitative care
- Vision care
- Chiropractic or alternative health care
- Medical services outside the service area

WHAT IS IMPORTANT TO ME?

Before choosing a health plan, decide what is most important to you. You may want to consider:

- How you feel about a primary care doctor making referrals for you
- How much responsibility, financially and otherwise, you are willing to take for your own healthcare
- Whether freedom to choose which doctor or hospital to use is important to you
- How comprehensive you want your healthcare coverage to be
- How important the cost is to you and how much you can pay in premiums, deductibles and other expenses
- Whether the plan offers benefits that meet your needs. Are you thinking about starting a family? Do you, or does a member of your family, have a chronic condition or disability?
- How does the plan provide coverage for family members who travel or attend college out of the state or out of the service area?

HOW DO I COMPARE PLANS?

When comparing the health plans, look at the services each plan offers. What services are limited or not covered (exclusions)? Which doctors, hospitals and other providers participate in the plan's networks (i.e., does your doctor participate)? Are the doctors accepting new patients? Do you need approval from the plan or your primary care physician before going to the hospital or receiving specialty care? Finally, compare the costs. Consider things such as: deductibles; copayments; how much the plan will pay once your deductible has been met; how much the plan will pay if you use a non-participating provider; and the limits on how much the plan will pay in a year or over a lifetime.

The State Health Plan

The State Health Plan offers two choices: the **Standard Plan** and the **Savings Plan**.

The **Savings Plan** was introduced in 2005. If you are willing to take greater financial responsibility for your healthcare costs and accept a higher annual deductible, you can save money on premiums by enrolling in the Savings Plan. Because it is a tax-qualified, high-deductible health plan, an eligible subscriber who enrolls in the Savings Plan and who has *no other health coverage, including Medicare, that is not a high-deductible health plan,* may establish a Health Savings Account (HSA). An HSA may be used to pay qualified medical expenses now and in the future.

Each plan has its own cost-sharing provisions. With the **Standard Plan,** the annual deductibles are lower, but the premiums are higher. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. Afterwards, the Standard Plan pays 100 percent of the allowable charges. However, per-occurrence deductibles still apply.

With the **Savings Plan**, the annual deductibles are much higher, but the premiums are much lower. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. The Savings Plan then pays 100 percent of allowable charges. There are no per-occurrence deductibles with the Savings Plan. However, no family member will receive benefits, other than preventive, until the $6,000 family deductible (or the $3,000 deductible if you have single coverage) has been met.

As part of the State Health Plan, the Standard Plan and the Savings Plan share many features:

THE STATE HEALTH PLAN HOSPITAL NETWORK

All general hospitals in South Carolina participate in the SHP hospital network. Network hospitals accept the State Health Plan's allowable charges for covered services and will not balance bill you for the difference. Network hospitals also file your claims. You pay only: the deductible; the coinsurance that applies to you; and any non-covered charges.

Services at non-network hospitals are covered, but non-network hospitals can balance bill you for the difference between the State Health Plan's allowable charge and their charge. You will also be responsible for paying an additional 20 percent in coinsurance, which is the out-of-network differential (see page 12).

THE STATE HEALTH PLAN PHYSICIAN NETWORK

If you need to see a medical doctor, you may benefit from using the SHP Physician Network. The SHP Physician Network is an open network, which means all eligible doctors in the state were invited to participate. Since network physicians have agreed to accept the Plan's allowable charges for covered medical services, you will pay only your deductibles, your coinsurance and any non-covered charges.

THE BLUECARD PROGRAM

You have access to doctors and hospitals almost everywhere with the BlueCard Program administered by BlueCross BlueShield of South Carolina. This program applies to your medical benefits. Please refer to the Behavioral Health Benefits section on page 16 to see how mental health and substance abuse benefits are handled. With the BlueCard Program, you still have the freedom to choose the doctors and hospitals that best suit you and your family. Follow these steps for health coverage when you are away from home within the United States:

1. Always carry your SHP ID card.

2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard *Access* at 800-810-2583.
4. Call Medi-Call for pre-authorization, if necessary.
5. When you arrive at the participating doctor's office or hospital, simply show your SHP ID card. As a BlueCard program member, the doctor should recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.

After you receive care, you should not have to complete any claim forms. You should not have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayment, coinsurance and non-covered services). You will be mailed a complete explanation of benefits.

OUTSIDE THE U.S.

Through the BlueCard Worldwide® program, your State Health Plan ID card gives you access to doctors and hospitals in more than 200 countries and territories around the world and to a broad range of medical assistance services.

A Note to Retirees

Remember that the Medicare Supplemental Plan follows Medicare rules. Since Medicare does not provide coverage outside the U.S. Territories, BlueCard Worldwide® coverage **is not** available to the Medicare Supplemental Plan subscribers.

AMBULATORY SURGICAL CENTER NETWORK

The Ambulatory Surgical Center Network includes ambulatory surgical centers around the state that provide some of the same services obtained from the outpatient department of a hospital. These surgical centers accept State Health Plan allowable charges and will not balance bill you for the difference. You just pay the applicable deductible and coinsurance. Medically necessary services at non-network ambulatory surgical centers are covered, but you may pay more.

OUT-OF-NETWORK BENEFITS

With the State Health Plan, you may choose which provider to use. However, if you choose a provider that does not participate in a SHP network or the BlueCard program, you will pay 20 percent more in coinsurance. This means that after you meet your deductible, you will be responsible for 40 percent of your covered expenses. Non-network providers are free to charge you any price for their services, so you may pay more than the State Health Plan's allowable charge.

Once you have met your deductible, here's how the **out-of-network differential** works if you are covered under the Standard Plan:

- If you have met your deductible and choose to see a non-network provider, you will be responsible for 40 percent, instead of the usual 20 percent, of the covered charges, any applicable per-occurrence deductibles, and you risk being balance billed. The plan will not begin paying 100 percent of your allowable charges until you have reached the out-of-network coinsurance maximum of $4,000 for single coverage and $8,000 for family coverage.

Once you have met your deductible, here's how the **out-of-network differential** works if you are covered under the Savings Plan:

- If you have met your deductible and choose to use a non-network provider, you will be responsible for 40 percent, rather than the usual 20 percent, of the covered charges. The plan will not begin paying 100 percent of your allowable charges until you have reached the out-of-network coinsurance maximum of $4,000 for single coverage and $8,000 for family coverage.

Prescription drug and mental health and substance abuse benefits are only payable *if* you use a network provider.

MEDI-CALL

Certain services covered by the Standard Plan and the Savings Plan require approval before you receive them. A phone call gets things started. While your healthcare provider may make the call for you, it is your responsibility to see that the call for authorization is made.

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m. Monday through Friday. The fax line can be used 24 hours a day. If you do fax information to Medi-Call, provide basic information so the approval process can begin. Be sure to include your name, your identification number, a note about the treatment requiring approval and a telephone number where you can be reached during business hours.

- 800-925-9724 (South Carolina, nationwide, Canada)
- 803-699-3337 (Greater Columbia area)
- 803-264-0183 (fax)

Medi-Call helps you and your covered family members receive appropriate medical care in the most beneficial, cost-effective manner. **Participation in Medi-Call is mandatory whether you are enrolled in the Standard Plan or in the Savings Plan.** You must contact Medi-Call at least 48 hours or two working days, whichever is greater, before receiving these medical services at any medical facility in the United States or Canada:

- You need inpatient care in a hospital[1]
- Your pre-authorized outpatient services result in a hospital admission (You must call again for the hospital admission.)
- You need outpatient surgery for septoplasty, hysterectomy or sclerotherapy
- You need a MRA, MRI or CT Scan
- You will be receiving chemotherapy or radiation therapy
- You are admitted to a hospital in an emergency (Your admission must be reported within 48 hours or the next working day.)[1]
- You are pregnant (You must call within the first three months of your pregnancy.)
- You have an emergency admission during pregnancy[2]
- Your baby is born[2]
- Your baby has complications at birth
- You are admitted to a skilled nursing facility, need home healthcare, hospice care or an alternative treatment program or need durable medical equipment
- You or your covered spouse decides to undergo any In Vitro Fertilization procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech and occupational therapies
- A pre-authorization request for any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days before surgery (i.e., blepharoplasty, reduction mammoplasty, TMJ or other jaw surgery, etc.)

[1]For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for pre-authorization before a non-emergency admission or within 24 hours of an emergency admission.
[2]Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by filing an NOE within 31 days of birth for benefits to be payable.

Medi-Call approval does not guarantee payment of benefits. Claim payments are still subject to the rules of the plan.

If you do not call Medi-Call in the required situations, you will pay a $200 penalty for each hospital or skilled nursing facility **admission.** In addition, the coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance, no matter how much you pay out-of-pocket. **If you do not obtain pre-authorization from APS, no mental health or substance abuse benefits will be paid.**

TRANSPLANT CONTRACTING ARRANGEMENTS

The SHP transplant contracting arrangements include the Blue Cross and Blue Shield Association (BCBSA) national transplant network, Blue Quality Centers for Transplants (BQCT). The BQCT is a national network of transplant centers. All of the centers in the BQCT network meet specific criteria that consider not only provider qualifications and program process, but also patient outcomes.

PREVENTIVE BENEFITS

WORKSITE SCREENING

Active employees and retirees who are not Medicare eligible and whose primary coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan, CIGNA HMO or MUSC Options can pay $15 for a routine health screening. This includes a health risk appraisal, blood lipid profile, blood chemistry profile, hemogram, blood pressure measurement, height and weight measurement and counseling on individual health risk factors. The screening, conducted at your worksite, is administered through Prevention Partners. You may participate in only one screening per year. Prevention Partners also conducts chronic disease management workshops on asthma, diabetes, hypertension and healthy heart. These workshops are held statewide and are free to employees and their family members. Contact your Prevention Partners coordinator or benefits office for more information.

Savings Plan participants receive a free annual physical, described on page 15.

MAMMOGRAPHY TESTING PROGRAM

Covered female subscribers within certain age ranges can obtain routine four-view mammograms at no cost at participating facilities throughout the state. There are no claim forms to file. A physician's referral is not required, but some facilities may ask for one. Routine mammograms are not covered at nonparticipating facilities in South Carolina and in the bordering states. Diagnostic mammograms are covered, subject to deductibles and coinsurance.

PAP TEST BENEFIT

The Plan will pay yearly for a Pap test if you are a covered woman age 18 through 65. This benefit applies whether the Pap test is routine or diagnostic. However, it does not include the office visit or other lab charges. Deductibles and coinsurance do not apply to this benefit.

MATERNITY MANAGEMENT PROGRAM

The Maternity Management Program is designed to help mothers-to-be covered by the State Health Plan receive prenatal care. The Medi-Call penalty ($200) will apply if you fail to contact Medi-Call during the first trimester to certify your pregnancy.

WELL CHILD CARE BENEFITS

Well Child Care benefits are free, and there are no claims to file when a doctor in the State Health Plan Physician Network provides the services. Covered dependent children, from birth through age 12, are eligible for the Well Child Care benefit. When you use a network doctor, the Well Child Care benefit pays 100 percent of the cost of covered childhood immunizations. When obtained from a network doctor, the Well Child Care benefit also provides 100 percent coverage for routine checkups at specified ages.

PREVENTIVE BENEFITS FOR SAVINGS PLAN PARTICIPANTS

Savings Plan participants are encouraged to take greater responsibility for their health. To make that easier, the plan offers additional preventive benefits at no cost. They include:

- Reimbursement for a yearly flu shot for each eligible participant
- Access to the 24-hour Health at Home® Nurseline, through which registered nurses provide personal, immediate assistance to subscribers
- A copy of the 416-page, full-color self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care*

Children age 12 and younger receive the Well Child Care benefits that are also offered to those enrolled in the Standard Plan. Savings Plan participants, age 13 and older, may receive from a network provider an annual physical that includes:

- A preventive, comprehensive examination
- A complete urinalysis
- An EKG
- A fecal occult blood test
- A general health laboratory panel "blood work"
- A lipid panel every five years
- A Pap test

Note: If your network physician uses a non-network physician or laboratory provider for testing, the tests will not be covered as part of the annual physical.

PRESCRIPTION DRUG BENEFITS

The Prescription Drug Program, administered by Medco, is easy and convenient to use. Please remember, **prescription drugs are only covered at network pharmacies**.

Under the **Standard Plan**:

- You show your SHP ID card when you purchase your prescriptions from a network pharmacy and pay a copayment of either $10 for generic drugs, $25 for preferred brand or $40 for non-preferred brand medications for up to a 31-day supply. You pay the full cost of the prescription if the price is less than the copayment. Prescription drug benefits are payable without an annual deductible, and there is an annual $2,500 copayment maximum per person.

Under the **Savings Plan**:

- You pay the full allowable cost of your prescription drugs when you purchase them. There are no copayments. This cost is transmitted electronically to BlueCross BlueShield of South Carolina. If you have not met your annual deductible, the full allowable cost of the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the allowable cost of the drug. The remaining 20 percent of the cost of the drug will be credited to your coinsurance maximum.

Both plans have a "**pay-the-difference**" policy. This means that if you purchase a brand-name drug when an equivalent generic drug is available, the plan will only cover the cost of the generic drug. This policy will apply even if the doctor prescribes the medication as "Dispense As Written" or "Do Not Substitute."

Under the **Standard Plan**, if you purchase a brand-name drug instead of a generic, you will be charged the generic copayment, PLUS the difference in price between the brand name and the generic drug. If this amount is less than the preferred or nonpreferred brand copayment, you will pay the applicable brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

Under the **Savings Plan**, if you purchase a brand-name drug instead of a generic, only the allowable cost for the generic drug will apply toward your deductible. After you have met your deductible, only the allowable cost of the generic drug will apply toward your coinsurance maximum. Non-sedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

Prescription drugs are also available by mail at a discount. For details, see the *2006 Insurance Benefits Guide.*

BEHAVIORAL HEALTH BENEFITS

Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and out-of-pocket maximums as medical claims. There are no caps on the number of provider visits.

If you need to see a mental health care provider when you are in or out of South Carolina, call APS Healthcare, toll-free at 800-221-8699, and you will be directed to a national network of providers. The mental health and substance abuse provider network operates just like the physician network. The major differences are that no benefits are paid if you use a hospital or provider that does not participate in the network, and services, including hospital admissions, are covered only if they are pre-authorized. The mental health and substance abuse provider network is an open network. This means that any eligible provider can participate in it. Your participating provider is responsible for submitting claims for these services, so there are no claims for you to file.

APS Healthcare also offers the Free & Clear® Quit for Life™ Program, a research-based tobacco cessation program, at no charge to State Health Plan subscribers and their dependents. To enroll in Free & Clear®, call 866-QUIT-4-LIFE (866-784-8454). After your eligibility is verified, you will be referred to a tobacco treatment specialist.

Remember, if you do not call APS Healthcare for pre-authorization or if you choose to use a non-network provider or hospital, no benefits will be paid. To review the network of providers, log on to the EIP Web site at www.eip.sc.gov, then choose your category and select "Online Directories," or go directly to www.apshealthcare.com. Once you are on APS' Web site, click on "Commercial Clients" in the top menu bar. Next, select "State of South Carolina" from the drop down list. Then click on "Online Provider Locator." You will need to enter SHP's access code, which is "statesc" (all lower case). Finally, click on "Accept."

State Dental Plan

The State Dental Plan is provided at no cost to active employees and funded retirees. You may add your eligible dependents for an additional premium, and they do not have to be enrolled in a state health plan. Dental plan benefits are divided into categories, or *classes* (see the table on page 17).

Dental Plus

Dental Plus provides a higher level of coverage for dental services covered under the State Dental Plan. It is not an offset program that pays what the State Dental Plan does not. Instead, it covers the *same procedures and services* (except orthodontia) at the *same percentage rate of coverage* as the State Dental Plan, but at a *higher allowance* (dollar amount) for the charges. Dental Plus provides this higher level of coverage at affordable rates.

You pay Dental Plus premiums with no contribution from the state. Active employee premiums can be paid on a pretax basis through MoneyPlu$. Dental Plus premiums are **in addition** to State Dental Plan premiums. Dental Plus subscribers are required to cover the same family members at the same level of coverage under both plans.

Under Dental Plus, reimbursement is based on what your dentist charges, up to the maximum Dental Plus allowance. The allowance is based on what most dentists in South Carolina charge for particular services. This means that your dental expenses will probably fall within these allowances, and you will only be responsible for paying the deductible and coinsurance. If your dentist charges more for covered services than Dental Plus allows, **you** will be responsible for paying the difference unless your dentist has agreed to accept the Dental Plus allowance.

The combined annual maximum benefit for the State Dental Plan and Dental Plus for services in classes I, II and III is $1,500 per covered person (compared to $1,000 with the State Dental Plan alone). There are no additional deductibles and coinsurance under Dental Plus.

Class	Services Covered	Plan	Yearly Deductible	Percent Covered	Maximum Benefit
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief X-rays	**State Dental Plan**	None	100% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	None	Up to 100% of allowance or actual charge (whichever is less)	$1,500[2] per person each benefit year combined for Classes I, II and III
II Basic Benefits	Fillings Simple extractions Oral surgery Surgical extractions Preparation of mouth for dentures	**State Dental Plan**	$25 per person. If you have services in Classes II and III, you still pay only one deductible. Limited to three per family per year.	80% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	No additional deductible	Up to 80% of allowance after State Dental Plan deductible is met	$1,500[2] per person each benefit year combined for Classes I, II and III
III Prosthodontics	Onlays Crowns Bridges Dentures Repair of prosthodontic appliances	**State Dental Plan**	$25 per person. If you have services in Classes II and III, you still pay only one deductible. Limited to three per family per year.	50% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	No additional deductible	Up to 50% of allowance after State Dental Plan deductible is met	$1,500[2] per person each benefit year combined for Classes I, II and III
IV Orthodontia[1]	Limited to covered children under age 19 Correction of malocclusion Consisting of: diagnosis (including models and X-rays) Active treatment (including necessary appliances)	**State Dental Plan**	None	50% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	**Dental Plus does not offer orthodontia benefits.**	**Dental Plus does not offer orthodontia benefits.**	**Dental Plus does not offer orthodontia benefits.**

[1] A subscriber must provide a letter from his provider stating that orthodontia is not for cosmetic purposes for it to be covered by the State Dental Plan.

[2] $1,500 is the total yearly benefit an individual may receive when enrolled in both the State Dental Plan and Dental Plus.

Life Insurance (for active employees only)

BASIC LIFE INSURANCE

The employer provides $3,000 group term life and accidental death and dismemberment coverage at no cost if you are enrolled in a health plan offered by EIP. The Hartford Insurance Company administers this benefit. If you leave your job, you may convert your coverage to an individual policy. To do so, you must apply to The Hartford in writing within 31 days of the date your insurance under this plan ends and pay the required premiums for your age and class of risk.

OPTIONAL LIFE INSURANCE

You can enroll in the Optional Life Insurance Plan within 31 days of the date you are hired. You do not have to be enrolled in health or dental coverage to participate in the Optional Life program. This policy includes life, accidental death benefits (including day care, education and felonious assault benefits), a prorated benefit for loss of eye or limb, a living benefit for employees under age 60, a 12-month waiver of premium for disability, and a seat belt provision of an additional 25 percent of the accidental death benefit (when applicable).

As a new employee, you can elect coverage in $10,000 increments, up to three times your basic annual earnings rounded down, without providing medical evidence of good health. You can select a higher benefit level in increments of $10,000, up to a maximum of $500,000, by providing medical evidence of good health. Your coverage begins on the first day of the month coinciding with, or the first of the month after, your date of employment if you are actively at work on that day as a full-time employee. If you apply for an amount of coverage that requires medical evidence of good health, your coverage effective date will be the first of the month after approval.

If you participate in the MoneyPlu$ Pretax Group Insurance Premium Feature, you can increase, decrease or drop your coverage only during October enrollment periods or within 31 days of a special eligibility situation. To increase your coverage during annual enrollment, you must provide medical evidence of good health and be approved by The Hartford. If approved, coverage will be effective on January 1 after annual enrollment as long as you are actively at work on that day as a full-time employee. You can increase your coverage due to a special eligibility situation in increments of $10,000, up to $50,000, without providing medical evidence of good health. You can increase your coverage further *with* medical evidence. Remember that a salary increase does not constitute a special eligibility situation. If you do not participate in the MoneyPlu$ Pretax Premium Feature, Optional Life enrollment and coverage changes are allowed year-round (subject to approval of medical evidence).

Through MoneyPlu$, you can pay Optional Life insurance premiums before you pay taxes. Your entire Optional Life insurance premium will be deducted from your paycheck before taxes. However, only premiums for coverage up to $50,000 will be tax exempt. Premiums paid for additional coverage (more than $50,000) will be added back into your earnings on your W-2 form at the end of the year. Please refer to the MoneyPlu$ section for enrollment information.

Your premiums will increase automatically each January 1 after you enter a new age bracket. When you retire, you may continue your coverage in $10,000 increments up to your active coverage level until age 75. Benefits are reduced by 35 percent at age 70. Premiums and reduced coverage levels are on pages 33-35. An employee leaving his job or retiring at age 75 can convert to a whole life policy up to the final face value of the coverage.

DEPENDENT LIFE INSURANCE

You do not have to be enrolled in health or dental coverage to enroll in the Dependent Life program. Dependents can be a spouse (who must not be eligible as an employee of a participating employer) and dependent children between the ages of 14 days and 19 years, or up to age 25 if they are full-time students. A child becomes ineligible for Dependent Life coverage at age 19 if he is not a full-time student, or at a younger age if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support. An incapacitated child becomes ineligible if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support.

DEPENDENT LIFE — SPOUSE

Within 31 days of the date you begin employment or within 31 days of your marriage, you can enroll your spouse for up to $20,000 in life insurance without providing medical evidence of good health. Medical evidence of good health is required for late entry for a spouse and for coverage in amounts greater than $20,000. If you are enrolled in Optional Life, you may cover your spouse in increments of $10,000, up to 50 percent of your Optional Life coverage or $100,000, whichever is less.

If you are not enrolled in Optional Life, you may elect coverage for your spouse in the amount of $10,000 or $20,000. Premiums for Dependent Life spouse coverage, just like Optional Life premiums, are based on the **employee's** age. You pay the premium with no contribution from the state, and it is payable through payroll deduction. The employee is the beneficiary.

DEPENDENT LIFE — CHILDREN

You can enroll your eligible dependent children for $10,000 in coverage. Medical evidence is not required to cover a child, even if the child is a late entrant. The monthly premium for Dependent Life child coverage is $1.24 regardless of the number of children covered. You pay the entire premium with no contribution from the state, and it is payable through payroll deduction.
Your dependent's coverage will end at midnight on the earliest of:

- The date the policy ends
- The date you, the employee, are no longer eligible for Dependent Life insurance coverage
- The date the dependent no longer meets the definition of a dependent or
- The date premiums for Dependent Life insurance coverage are due and unpaid for a period of 31 days

If your dependent's coverage ends because of one of the reasons above, he may convert his coverage to a personal life insurance policy. To do so, the dependent must apply to The Hartford in writing within 31 days of the date his insurance under this plan ends and pay the required premiums for his age and class of risk.

MoneyPlu$

MoneyPlu$ is a program that enables you to save money on eligible medical and dependent care costs by permitting you to pay these expenses with income deducted from your salary before it is taxed.

- **Pretax Premiums** (for active employees)
  The Pretax Group Insurance Premium Feature allows you to pay your State Health Plan, HMO, State Dental Plan, Dental Plus and Optional Life (for coverage up to $50,000) premiums before taxes are taken from your paycheck.

- **Flexible Spending Accounts** (for active employees—To participate in the Medical Spending Account, you must have completed one year of continuous state service by January 1 after annual enrollment.)
  MoneyPlu$ allows you to pay eligible medical and dependent care expenses with money before it is taxed. You authorize deposits to your MoneyPlu$ account every pay period, before your salary is taxed. As you incur eligible expenses, you request tax-free withdrawals from your account to reim-

burse yourself. There are three kinds of MoneyPlu$ accounts: a **Medical Spending Account**, a **limited-use Medical Spending Account** that can accompany a Health Savings Account and a **Dependent Care Spending Account**. If you incur dependent care and medical expenses, you can establish both a dependent care account and a Medical Spending Account or a limited-use Medical Spending Account.

- **Health Savings Accounts** (for active employees and non-Medicare eligible retirees)
  A MoneyPlu$ Health Savings Account (HSA) is available to subscribers enrolled in the SHP Savings Plan and can be used to pay healthcare expenses. Unlike money in a MoneyPlu$ Medical Spending Account, the funds do not have to be spent in the year they are deposited. Money in the account accumulates tax free, so the funds can be used to pay qualified medical expenses in the future. An important advantage of the HSA is that you own it. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

ADMINISTRATIVE FEES

Pretax Group Insurance Premium Feature:
$0.12 per month
Dependent Care Spending Account:
$2.50 per month
Medical Spending Account or limited-use MSA: $2.50 per month
All fees are deducted from your paycheck before taxes.

For more information about the EZ REIMBURSE MasterCard, please consult the *2006 Insurance Benefits Guide*, pages 123-126.

EZ REIMBURSE® MasterCard® Card (issued by MetaBank) $20 per year
The fee for this optional debit card will be deducted from your Medical Spending Account. If your account contains $2,500 or more, this fee is waved.

Health Savings Account:
- $20 per year or $2 per month (your choice)
- $0.50 per check if you are reimbursed by check.
- No charge if you use your VISA® debit card.
- There may be additional fees for other services. All fees are deducted from your HSA.

Disability Insurance

BASIC LONG TERM DISABILITY (BLTD)

BLTD is an employer-funded disability plan for active employees who are enrolled in a health plan offered by the Employee Insurance Program. BLTD provides a benefit of 62.5 percent of the employee's gross monthly salary, less other sources of income, up to a maximum benefit of $800 per month. There is no minimum benefit if these offsets exceed 62.5 percent of the employee's gross monthly salary. BLTD has a 90-day benefit waiting period.

Upon approval, these taxable benefits are payable for up to 24 months if an employee is unable to perform the duties of his own general occupation, and up to age 65 or older, in some circumstances, if an employee is unable to perform the duties of any and all occupations which he is able to perform, due to education, training or experience. These alternative occupations must be available at one or more locations in the national economy. They must be occupations in which the employee can be expected to earn at least 65 percent of his pre-disability earnings (adjusted for inflation) within 12 months following his return to work, regardless of whether the employee is working in his previous occupation or any other occupation. In addition, there is a two-year limit on benefits for certain medical conditions.

BLTD is provided to active employees only and cannot be continued upon retirement.

SUPPLEMENTAL LONG TERM DISABILITY (SLTD)

SLTD is a voluntary program in which the employee pays all premiums. This benefit pays 65 percent of the employee's gross monthly salary, less other sources of income, including the BLTD benefit, up to a monthly maximum of $8,000. If these other sources of income (called "offsets") exceed 65 percent of the employee's gross monthly salary, the plan will pay a minimum of $100 per month.

These non-taxable benefits are payable for 24 months if an employee is unable to perform the duties of his own occupation, and up to age 65 or older, in certain circumstances, if the employee is unable to perform the duties of any and all jobs which he is able to perform, due to education, training or experience. These alternate occupations must be available at one or more locations in the national economy. They must be occupations in which the employee can be expected to earn at least 65 percent of his pre-disability earnings (adjusted for inflation) within 12 months following his return to work, regardless of whether the employee is working in his previous occupation or any other occupation. In addition, there is a two-year limit on benefits for certain medical conditions.

The SLTD policy incudes a "Lifetime Security Benefit." This benefit is designed to extend SLTD benefits indefinitely for a disabled person who is suffering from severe cognitive impairments or who is unable to perform two or more activities of daily living. The activities of daily living considered are bathing, continence, dressing, eating, toileting and transferring.

At enrollment, the employee may choose either a 90-day or 180-day benefit waiting period. Premiums are based on the employee's age and salary. If the employee does not enroll in SLTD within 31 days of being hired, he may apply throughout the year by providing medical evidence of insurability. An employee must also provide medical evidence of insurability if he chooses to change his benefit waiting period from 180 to 90 days.

Generally, you may not continue SLTD coverage in retirement. However, if you are retiring or leaving employment, but plan to work for an employer that does not have a supplemental long term disability program, contact EIP for more information about continuing coverage through Standard Insurance Company.

COMPARISON OF BLTD AND SLTD PROGRAMS

	BLTD	SLTD
Eligibility	Must be enrolled in a state health plan	Voluntary program
Premium payment	Employer pays monthly premium	Employee pays monthly premium
Benefit waiting period	90-day waiting period	Employee chooses 90-day or 180-day waiting period
Maximum benefit	Monthly benefit is 62.5% of gross monthly salary*: $800 maximum with offsets	Monthly benefit is 65% of gross monthly salary*: $8,000 maximum with offsets
Minimum benefit	No minimum monthly benefit if offsets exceed 62.5% of gross monthly salary*	$100 per month minimum if offsets exceed liability
Taxability of Benefits	Yes	No

** Gross monthly salary is based upon the rate of pay on January 1 preceding the disabling event.*

Long Term Care Insurance

Long Term Care (LTC) is the day-to-day assistance that you need when you have a serious illness or disability that lasts for an extended period of time and you are not able to take care of yourself. Long Term Care includes a wide range of services that can be provided in your home, an adult day-care center, an assisted-living facility, a nursing home or a hospice. The Employee Insurance Program and Aetna, the state's Long Term Care program underwriter, offer you the Long Term Care Insurance Plan, with three plan options that are designed to protect your assets from depletion by the costs of long term care.

Full-time, permanent employees may enroll in the LTC Insurance Plan within 31 days of their hire date, without providing medical evidence of good health. Current full-time, permanent employees may enroll throughout the year, with approval of medical evidence of good health. Spouses, parents and parents-in-law of eligible employees may enroll throughout the year with approval of medical evidence of good health. A spouse, parent or parent-in-law is eligible to apply for enrollment even if the employee does not enroll. There is a ten percent discount in premiums if both an employee and spouse enroll in the Service Reimbursement plans.

There are three LTC plans from which to choose: a disability plan and two service reimbursement plans. LTC plan premiums are on pages 36-38.

LTC PLAN COMPARISON

	Disability Plan (Option #1)	Service Reimbursement Plan (Option #2)	Service Reimbursement Plan (Option #3)
Daily Benefit Amount (DBA)	$50 - $250 in $10 increments.	$50 - $350 in $10 increments.	$50 - $350 in $10 increments.
Lifetime Maximum Benefit Amount	5 years x DBA	5 years x DBA	5 years x DBA
Nursing Facility or Hospice Care	You receive 100% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Assisted Living Facility Care	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Community-Based Services	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Informal Care	You receive 50% of your Daily Benefit Amount.	25% of your Daily Benefit Amount up to 100 days each calendar year.[1]	25% of your Daily Benefit Amount up to 50 days each calendar year.[1]
Alternate Care	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Transitional Care	You receive 50% of your Daily Benefit Amount.	You receive 3 times your Daily Benefit Amount.[2]	You receive 3 times your Daily Benefit Amount.[2]
Caregiver Training	You receive 50% of your Daily Benefit Amount.	You receive the lesser of 100% of the actual expenses or 3 times your DBA.[1]	You receive the lesser of 100% of the actual expenses or 3 times your DBA.[1]
Respite Care	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 50% of your Daily Benefit Amount for 21 days each calendar year.[1]	You receive your actual expenses, up to 100% of your Daily Benefit Amount for 21 days each calendar year.[1]

[1]Not subject to lifetime maximum.
[2]Not subject to lifetime maximum, paid only once in a lifetime.

Vision Care Program

If you are a full-time or part-time employee, retiree, survivor or COBRA participant, you may take advantage of this program. Your dependents also are eligible. You do not have to subscribe to the State Health Plan or an HMO. Tell your provider you are a participant in the Vision Care Program. If you don't, you may not receive the discount. You may be required to show your provider some type of state-related identification to prove your eligibility.

Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $60 for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may have to pay additional charges because that usually requires additional services.

Participating providers, including opticians, have agreed to give a 20 percent discount on all eyewear. The discount does not apply to disposable contact lenses. Participating providers are listed in the Vision Care Program Directory available on the EIP Web site at www.eip.sc.gov. The Vision Care Program is not associated with any state group health coverage. There are no claims to file and no reimbursement of fees.

If you are covered under another vision care program, you can have the benefits offered under this program or through your other coverage, but not both.

Late Entry and Making Coverage Changes

HEALTH PLANS

If you and/or any of your eligible dependents do not enroll in the State Health Plan or an HMO within 31 days of eligibility, you will be considered a late entrant. You must wait until the next open enrollment period, held in October of odd-numbered years, or a special eligibility situation, to enroll.

Enrollment and changes not made within 31 days of the date of hire or special eligibility situation cannot be made until the next open enrollment period or within 31 days of the next special eligibility situation. Coverage will be effective the following January 1 for changes made during open enrollment. Late entrants are subject to an 18-month pre-existing condition limitation period.

DENTAL PLANS

If you and/or any of your eligible dependents do not enroll in the State Dental Plan or Dental Plus within 31 days of eligibility, you must wait to enroll until the next open enrollment period or special eligibility situation. Coverage will be effective the following January 1 for changes made during open enrollment.

LIFE INSURANCE

If you do not enroll in the Optional Life Insurance program within 31 days of your date of hire, you may apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. If you participate in the MoneyPlu$ Pretax Group Insurance Premium Feature, you may enroll only within 31 days of a special eligibility situation or during the annual enrollment period (Approval of medical evidence will be required, and coverage will be effective the following January 1.)

If you do not enroll your dependent spouse in the Dependent Life Insurance program within 31 days of your date of hire or a special eligibility situation, you can apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. Dependent children can be enrolled at any time throughout the year. Medical evidence of good health is not required.

SUPPLEMENTAL LONG TERM DISABILITY

If you do not enroll in the Supplemental Long Term Disability (SLTD) program when first eligible, or wish to decrease your benefit waiting period from 180 days to 90 days, you can do so throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval.

LONG TERM CARE

If you do not enroll in the LTC program when first eligible, or you wish to increase your coverage, you can apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. Your spouse, parents and parents-in-law may enroll throughout the year with approval of medical evidence of good health.

SPECIAL ELIGIBILITY SITUATIONS

Coverage changes allowed due to a special eligibility situation must be made within 31 days of the date of occurrence. Special eligibility situations include:

- Marriage
- Birth, adoption or placement for adoption
- Divorce or legal separation
- Spouse becomes a state employee
- Spouse loses or gains employment
- Spouse retires
- Child turns age 19 and is not a full-time student
- Child age 19 through 24 becomes a full-time student
- Child is a full-time student who turns age 25
- Child becomes incapacitated before age 19 or before age 25 if a full-time student
- Death of a covered dependent and
- Child marries or is no longer principally dependent (more than 50 percent) on the employee for support and maintenance

SPECIAL ELIGIBILITY SITUATIONS AND OPTIONAL LIFE INSURANCE

Employees participating in the MoneyPlu$ Pretax Group Insurance Premium Feature are subject to MoneyPlu$ regulations and must make all requests within 31 days of a special eligibility situation or wait until an annual enrollment period to make changes.

Employees **not** participating in the MoneyPlu$ Pretax Group Insurance Premium Feature may add Optional Life or increase the level of coverage year-round by providing medical evidence of good health. Employees not participating in the MoneyPlu$ Pretax Group Insurance Premium Feature may cancel Optional Life coverage or decrease the level of coverage effective the first of the month after the request.

CHANGES YOU MAY MAKE THROUGHOUT THE YEAR

ADDING/CHANGING COVERAGE

- You may enroll yourself and any eligible dependents in a health and/or dental plan within 31 days of a special eligibility situation. You may enroll only those dependents for whom the situation applies; you may not enroll other dependents for whom there is no special eligibility situation. You must file an NOE and documentation within 31 days of the event. Changes not made within 31 days of the special eligibility situation may not be made until the next open enrollment period or special eligibility situation.

- You may enroll yourself and/or your spouse in the Long Term Care (LTC) Insurance program, or increase your coverage level, upon approval of medical evidence of good health. For more information, contact Aetna, underwriter of the LTC program.

DECREASING COVERAGE

- You may decrease your coverage level for health and dental if a spouse or dependent child becomes ineligible. Reasons for ineligibility include: spousal divorce or separation; child turns age 19 and is not a full-time student; child turns age 25, child marries or is no longer principally dependent (more than 50 percent) on the employee for maintenance and support. Changes should be requested within 31 days of ineligibility.

Tips for Completing the NOE

Notice of Election (NOE) forms are available on the EIP Web site at www.eip.sc.gov. You may complete an NOE in one of two ways:

- *Interactively*—Type information directly into the spaces provided, print the completed form, sign it and submit it to your benefits administrator. Be careful to click on only one box or selection when only one choice is allowed (such as choice of health plan).
- *Manually*—Print the form, fill it out by hand and submit it. If your BA can submit your NOE electronically, they will let you know before you fill it out.

If you have Internet access, you are encouraged to use the interactive NOE on the EIP Web site. However, for those who do not have access to the Web, printed NOEs are available from your benefits administrator.

GENERAL TIPS

- Use black ink when filling out the form by hand and when you sign it.
- Mark only the benefits in which you are enrolling.
- Review the NOE for accuracy, required documentation and for your signature.
- If you have any questions about completing the form, refer to the instructions on page 2 of the form or ask your benefits administrator.

1. ADMINISTRATIVE INFORMATION

Complete the information, except for the block "BA USE ONLY." Be sure to check "Y" or "N" in the MoneyPlu$ block to indicate whether you want your health, dental and/or Optional Life insurance premiums to be deducted from your paycheck on a pretax basis.

2. ENROLLEE INFORMATION

Complete all relevant information, including your phone number at work and an e-mail address if you have one.

- If you are completing the form online, a scrolling list of county code numbers appears for box #17. If you are completing the form manually, check with your benefits administrator for the correct county code number.

3. MEDICARE

This information will be used to determine eligibility for enrolling in the Savings Plan as well as for coordination of benefits, including prescription drug benefits.

- **MEDICARE PART A AND/OR PART B.** List yourself and any other covered dependents who are eligible for Part A or Part B of Medicare and check the reason for eligibility.

(tips continued on page 29)

Sample Notice of Election Form (NOE)
Page 1

REFRESH

South Carolina State Budget and Control Board Employee Insurance Program Active Notice of Election (NOE)

1 ADM INFO

Check One:	Type of Change	BA Use Only	MoneyPlus
☐ New Hire ☐ Transfer ☐ Change	☐ Enrollment ☐ Other *(specify)* _____ ☐ Address Date of Occurrence: _____	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)* Group ID#: _____ Group Name: _____	☐ Yes ☐ No **Health Savings Account** ☐ Yes ☐ No *(For Use with Savings Plan)*

2 ENROLLEE INFO

1. Social Security Number	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM/DD/YYYY

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	( )	( )	

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Date of Hire MM/DD/YYYY
			SC				

3 MEDICARE

LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR PART B OF MEDICARE.

20. NAME	MEDICARE#	ENTITLED DUE TO	EFFECTIVE DATE PART A MM/DD/YYYY	EFFECTIVE DATE PART B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

4 BENEFITS

21. HEALTH PLAN *(Refuse or select one plan and one category)*

PLAN
☐Refuse ☐Standard ☐HMO_____ *Name of HMO*
☐Savings (Non-Medicare)
☐TRICARE Supplement (Non-Medicare)

CATEGORY
☐Enrollee ☐Enrollee/Child(ren)
☐Enrollee/Spouse ☐Family

22. STATE DENTAL PLAN *(Select One)*
☐Refuse ☐Enrollee/Spouse ☐Enrollee/Child(ren) ☐Enrollee ☐Family

23. DENTAL PLUS *(Select One)*
☐Refuse ☐Yes

24. DEPENDENT LIFE - Child(ren) *(Select One)*	25. DEPENDENT LIFE - Spouse *(Select One)*	26. OPTIONAL LIFE *(Select One)*	27. SUPPLEMENTAL LTD *(Select One)*	28. BASIC LIFE/BASIC LTD
☐Refuse ☐$10,000	☐Refuse ☐Coverage Level $_____ *(Must be in increments of $10,000)*	☐Refuse ☐Coverage Level $_____ *(Must be in increments of $10,000)*	☐Refuse/Cancel ☐Plan One - *90 day benefit waiting period* ☐Plan Two - *180 day benefit waiting period*	Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.

5 BENEFICIARIES INFO

In blocks 29, 30 and 31, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

Basic Life or Optional Life *(Check one or both)*	29. SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent
☐Basic Life ☐Optional Life						
☐Basic Life ☐Optional Life						

If Beneficiary is an organization or trust, complete the following:
Organization/Trust_____Address_____If Trust, Date signed_____

6 DEPENDENT INFORMATION

List spouse and eligible children to be covered. If they are not listed, they will not be covered. Is your spouse a state employee or retiree? ☐YES ☐NO

Add (A) or Delete (D)	30. Dependent SSN#	Last Name	First Name	SEX M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Status
	Spouse						Spouse employed by state covered entity ☐Yes ☐No
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated

31. Does your dependent(s) have other health coverage? ☐YES ☐NO Does this coverage include pharmacy benefits? ☐YES ☐NO

If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing conditions, if applicable.

DEPENDENT NAME	INSURANCE COMPANY	POLICY HOLDER DATE OF BIRTH	EFFECTIVE DATE OF POLICY	TERMINATION DATE *(If Applicable)*

7 CERTIFICATION & AUTHORIZATION

32. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided social security numbers and documentation establishing my dependent(s) eligibility for the plan(s) selected. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period every two years. Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period every two years unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES WHETHER WRITTEN OR ORAL WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THE PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature _____ Date _____

33. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Date _____

EIP REV. 9/05

Sample Notice of Election Form (NOE)
Page 2

EMPLOYEE INSURANCE PROGRAM INSTRUCTIONS FOR ACTIVE NOTICE OF ELECTION

IF COMPLETING BY HAND USE BLACK INK

ADMINISTRATIVE INFORMATION: Indicate type of action to be taken. MONEYPLUS: Premiums for health/dental and optional life are deducted on a pretax basis. There is an administrative fee for the pretax deductions. MoneyPlus changes are limited by IRS restrictions and must be made during enrollment or within 31 days of the date of occurrence of a qualifying change in family status. HEALTH SAVINGS ACCOUNT: To be used with Savings Plan and is governed by IRS regulations.

ENROLLEE INFORMATION: Blocks 1-19 must be completed for all transactions, including a refusal.

MEDICARE: Block 20. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

BENEFITS: Alterations in this section are not allowed.

Block 21. HEALTH: Prior to making a health plan selection, refer to the plan descriptions provided by your employer.

To decline health coverage, check "Refuse". If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can apply for coverage for yourself and/or your dependent(s) only during an announced open enrollment period every two years. If health coverage is refused, benefits for Basic Life and Basic LTD are forfeited.

To select a health plan, check only one block.

To select a category, check only one block. In order for dependent(s) to be covered, they must be listed in Block 30, and the appropriate category must be selected.

Block 22. DENTAL: To decline dental coverage, check "Refuse". If you refuse dental now, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period every two years.

To select coverage, check only one block. In order for dependents to be covered, they must be listed in Block 30, and the appropriate category must be selected.

Block 23. DENTAL PLUS: To select Dental Plus coverage, check "yes;" to refuse coverage select "refuse". You must enroll in basic dental coverage to enroll in Dental Plus. Coverage level in Dental Plus must equal coverage level in basic dental plan.

Block 24. DEPENDENT LIFE—CHILD(REN): To decline or cancel coverage, check "Refuse". To select coverage, check block. In order for dependents to be covered, they must be listed in Block 30.

Block 25. DEPENDENT LIFE —SPOUSE: Prior to making a selection, refer to the detailed instructions provided by your employer.

To decline or cancel coverage, check "Refuse". To select coverage, check block and enter coverage level for your spouse based on your current level of Optional Life and/or approved medical evidence of good health. In order for your spouse to be covered, he/she must be listed in Block 30.

Block 26. OPTIONAL LIFE: Prior to making a selection, refer to the detailed instructions provided by your employer.

To decline coverage or cancel coverage, check "Refuse". To select coverage, check block and enter coverage level. Coverage level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 31 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus pretax premium feature, you must wait until the next announced enrollment period or within 31 days of a special eligibility situation.

Block 27. SUPPLEMENTAL LONG TERM DISABILITY: Prior to making a selection, refer to the detailed instructions provided by your employer.

To decline coverage or cancel coverage, check "Refuse". To select coverage, check only one block. If changing from "Plan Two" to "Plan One," medical evidence of good health must be provided.

Block 28. BASIC LIFE AND BASIC LTD: Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.

BENEFICIARIES INFORMATION: Block 29. List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a given name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights unless all primary beneficiaries have died.

DEPENDENT INFORMATION: Block 30. If you select a category with spouse/dependent child(ren), they must be listed to be covered. A spouse can only be covered as a dependent if not a state employee. A state employee is defined as an employee of a state agency, public school district, county, municipality, local subdivision or other entity participating in the State of South Carolina Insurance Benefits Program. If spouse is a State employee or is employed at a state covered entity, check "yes." Legal documentation is required for all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister, adopted child). In order for children age 19 through 24 to be considered eligible for coverage, the dependent must be a full-time student (TRICARE Supplement age 21 through 23) or incapacitated (documentation required for both). Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

Block 31. If you checked "yes," list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check "no," and list the termination date of the policy.

CERTIFICATION AND AUTHORIZATION: Form must be signed and dated by employee within 31 days of hire or the qualifying event.

Benefits Administrator must sign and date form and attach all supporting documentation prior to submitting it to the Employee Insurance Program at P.O. Box 11661 Columbia, SC 29211-1661.

Tips for Completing the NOE (continued)

4. BENEFITS

- You select or refuse your plans and coverage in this section.
- If you choose an **HMO** (with or without the point-of-service option), write the full name of the HMO: *BlueChoice HealthPlan, CIGNA HMO* or *MUSC Options.* The HMO that you choose will work directly with you in designating a primary care physician.
- You may enroll in **Optional Life** for up to three times your salary, rounded down to the nearest $10,000. You may also enroll for additional coverage by providing medical evidence of good health. If you choose to enroll for more than three times your salary, you will need to complete an NOE indicating your chosen level of coverage and a Personal Health Statement (PHS) from The Hartford. The Personal Health Statement is available on the EIP Web site at www.eip.sc.gov or from your benefits administrator.

5. BENEFICIARIES INFORMATION

In this section, you designate any beneficiaries to receive your life insurance in the event of your death. If more than one beneficiary is designated, they will share equally unless you specify otherwise by indicating percentages to each.

- Indicate whether they are primary beneficiaries or contingent beneficiaries. Contingent beneficiaries are paid only if any and all primary beneficiaries have predeceased the employee.
- If you are naming an organization or trust as beneficiary, you must complete the additional information requested.

6. DEPENDENT AND OTHER COVERAGE INFORMATION

- A checkbox is located at the start of this section to indicate whether your spouse is also employed by a participating employer.
- Be sure to **include the dependent's Social Security Number.**
- Indicate whether any dependent child who is older than 19 is a full-time student or is incapacitated and attach the appropriate documentation as required, such as a letter of certification from the academic institution or an Incapacitated Child Certification Form.
- Indicate if your dependent(s) have other group health coverage, including pharmacy benefits. Attach a list of any covered dependents who have other group health insurance coverage. This information is used for coordination of benefits and for updating EIP's records if a dependent has terminated other coverage. For example, if a dependent child has terminated other group coverage, you should indicate the termination date.

If you or your dependents had other coverage within 62 days of the effective date of coverage indicated on the NOE, attach a certificate of coverage from the previous insurer to offset any pre-existing condition limitations.

7. CERTIFICATION & AUTHORIZATION

Read the certification and authorization before you sign the form. Return the completed form to your benefits administrator.

Comparison of Health Plan

Plan	SHP Savings Plan		SHP Standard Plan[3]	
Availability	Coverage worldwide		Coverage worldwide	
Active Employee Monthly Premiums *Employee Only* *Employee/Spouse* *Employee/Children* *Full Family*	**$ 9.28** **$ 72.56** **$ 20.28** **$108.56**		**$ 93.46** **$237.50** **$142.46** **$294.58**	
	Please note that premiums for optional employer groups, such as local subdivisions, may vary.			
Annual Deductible *Single* *Family*	**(no per-occurrence deductibles)** **$3,000** **$6,000[4]**		**$350** **$700**	
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%
Coinsurance Maximum *Single* *Family*	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**
Physicians Office Visits	Chiropractic payments limited to **$500** a year, per person No per-occurrence deductible or copayments		**$10** per-occurrence deductible, then:	
	In-network Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%
Hospitalization/ Emergency Care	No per-occurrence deductibles or copayments		Outpatient hospital: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible	
Prescription Drugs	Participating pharmacies and mail order only: You pay the State Health Plan's allowable cost until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable cost; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable cost.		Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand Out-of-pocket max: **$2,500**	

[1]This table is for comparison purposes only.
[2]There will be no copayment for services performed at MUSC outpatient facilities.
[3]Refer to the Retiree chapter in the *2006 Insurance Benefits Guide* for information on how this plan coordinates with Medicare.
[4]If more than one family member is covered, no family member will receive benefits, other than preventive, until the $6,000 annual family deductible is met.

Benefits Offered for 2006[1]

	BlueChoice HealthPlan of South Carolina[3]	CIGNA HMO[3]	MUSC Options[3]		Medicare Supplemental Plan[3]
	Available in all South Carolina counties Coverage worldwide	Available in all South Carolina counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, McCormick and Saluda counties*	Available in these South Carolina counties: *Berkeley, Charleston, Colleton and Dorchester counties*		Same as Medicare Available to retirees and covered dependents/survivors who are eligible for Medicare
	$125.30 **$365.72** **$268.46** **$540.18**	**$127.00** **$365.18** **$267.12** **$536.98**	**$119.24** **$335.38** **$223.56** **$431.82**		For rates, refer to the premium tables on pages 172 and 173 of the *2006 Insurance Benefits Guide*
	To verify your rates, contact your benefits office.				
	$250 **$500**	NONE	**In-network** NONE	**Out-of-network** **$300** **$900**	Pays Medicare Part A and Part B deductibles; $200 private duty nursing
	HMO pays 90% after copays You pay 10%	HMO pays 80% after copays You pay 20%	HMO pays 100% after copays	HMO pays 60% of allowance You pay 40%	Pays Part B coinsurance of 20%
	$1,500 **$3,000** **(excludes deductible and copayments)**	**$3,000** **$6,000** **(includes inpatient, outpatient, copays and coinsurance)**	N/A	**$3,000** **$9,000** **(excludes deductible)**	None
	$15 PCP copayment **$15** OB/GYN well woman exam **$30** specialist copay	**$20** PCP copayment **$40** OB/GYN exam **$40** specialist copay	**$15** PCP copay; **$15** OB/GYN well woman exam, 2 self-referred visits yearly; **$25** specialist copay with referral; **$45** specialist copay without referral	HMO pays 60% of allowance after annual deductible You pay 40%. No preventive care benefits out-of-network	Pays Part B coinsurance of 20%
	Inpatient: **$200** copay Outpatient: **$75** copay/first 3 visits Emergency care: **$100** copay HMO pays 90% after copays You pay 10% **$35** urgent care copay, then HMO pays 100%	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Inpatient: **$300** copay Outpatient facility: **$100**[2] copay Emergency Care: **$100** copay; **$35** urgent care copay	HMO pays 60% of allowance after annual deductible You pay 40% Emergency care: **$100** copay	**For inpatient hospital stays**, the Plan pays: Medicare deductible; coinsurance for days 61-90; coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required) **For skilled nursing care**, the Plan pays coinsurance for days 21-100; 100% beyond 100 days, up to $6,000 or 60 days, whichever is less.
	Participating pharmacies only (31-day supply): **$8** generic, **$30** preferred brand, **$50** non-preferred brand, **$75** specialty pharmaceuticals Mail order (Up to 90-day supply): **$16** generic, **$60** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic, **$25** preferred brand, **$50** non-preferred brand Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$15** generic, **$50** preferred brand, **$80** non-preferred brand		Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand; Out-of-pocket max: **$2,500**

2006 Premiums

2006 Monthly Employer Contributions[1]

EMPLOYER					
	Health	**TRICARE Supplement**	**Dental**	**Life**	**LTD**
Employee Only	$231.84	$63.50	$11.71	$0.35	$3.23
Employee/Spouse	$453.02	$122.50	$11.71	$0.35	$3.23
Employee/Child	$327.18	$122.50	$11.71	$0.35	$3.23
Full Family	$529.00	$163.50	$11.71	$0.35	$3.23

[1]Rates for employers of local subdivisions may vary. To verify your employer's rates, contact your benefits office.

2006 Active Employee Monthly Premiums[2]

HEALTH EMPLOYEE						
	Savings	**Standard**	**BlueChoice**	**CIGNA**	**MUSC**	**TRICARE Supplement**
Employee Only	$9.28	$93.46	$125.30	$127.00	$119.24	$0.00
Employee/Spouse	$72.56	$237.50	$365.72	$365.18	$335.38	$0.00
Employee/Child	$20.28	$142.46	$268.46	$267.12	$223.56	$0.00
Full Family	$108.56	$294.58	$540.18	$536.98	$431.82	$0.00

[2]Rates for employees of local subdivisions may vary. To verify your rates, contact your benefits office.

2006 Active Employee Monthly Dental Premiums

DENTAL EMPLOYEE		
	Basic	**Dental Plus**
Employee Only	$0.00	$18.52
Employee/Spouse	$7.64	$35.06
Employee/Child	$13.72	$38.26
Full Family	$21.34	$54.80

2006 Supplemental LTD Monthly Premium Rate

SUPPLEMENTAL LTD			
AGE	**90 DAY**	**180 DAY**	**STEPS TO CALCULATE SLTD MONTHLY PREMIUM**
< 31	0.00065	0.00050	1. Always select floating decimal (F) on your calculator.
31 - 40	0.00089	0.00069	2. Divide gross annual salary by 12 to determine monthly salary.
41 - 50	0.00179	0.00137	3. Multiply monthly salary by rate factor from table.
51 - 60	0.00360	0.00277	4. Drop digits to right of 2 decimal places; do not round.
61 - 65	0.00433	0.00333	5. If number is even, this is the monthly premium.
> 65	0.00528	0.00406	6. If number is odd, add .01, this is the monthly premium.

2006 MoneyPlu$ Monthly Administrative Fees

Pretax Group Insurance Premium Feature[1]	$0.12 per month
Dependent Care Spending Account[1]	$2.50 per month
Medical Spending Account or Limited-Use MSA[1]	$2.50 per month
EZ REIMBURSE® MasterCard®[2]	$20 per year

Health Savings Account[3]	$20.00 per year or $2.00 per month (your choice)
Reimbursement by check	$0.50 per check
Use of your VISA® debit card	$0.00

[1]These fees are deducted from your paycheck before taxes.
[2]The fee for this optional debit card will be deducted from your Medical Spending Account.
[3]There may be additional fees for other services. All fees are deducted from your HSA.

2006 Optional Life, Dependent Life Spouse Monthly Premiums Monthly Rates for Employees through age 69

	Employee's Age*							
	<35	**35 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**65 - 69**
Coverage								
$10,000	$0.68	$0.80	$1.26	$1.76	$2.74	$4.28	$6.56	$9.78
$20,000	$1.36	$1.60	$2.52	$3.52	$5.48	$8.56	$13.12	$19.56
$30,000	$2.04	$2.40	$3.78	$5.28	$8.22	$12.84	$19.68	$29.34
$40,000	$2.72	$3.20	$5.04	$7.04	$10.96	$17.12	$26.24	$39.12
$50,000	$3.40	$4.00	$6.30	$8.80	$13.70	$21.40	$32.80	$48.90
$60,000	$4.08	$4.80	$7.56	$10.56	$16.44	$25.68	$39.36	$58.68
$70,000	$4.76	$5.60	$8.82	$12.32	$19.18	$29.96	$45.92	$68.46
$80,000	$5.44	$6.40	$10.08	$14.08	$21.92	$34.24	$52.48	$78.24
$90,000	$6.12	$7.20	$11.34	$15.84	$24.66	$38.52	$59.04	$88.02
$100,000	$6.80	$8.00	$12.60	$17.60	$27.40	$42.80	$65.60	$97.80
$110,000	$7.48	$8.80	$13.86	$19.36	$30.14	$47.08	$72.16	$107.58
$120,000	$8.16	$9.60	$15.12	$21.12	$32.88	$51.36	$78.72	$117.36
$130,000	$8.84	$10.40	$16.38	$22.88	$35.62	$55.64	$85.28	$127.14
$140,000	$9.52	$11.20	$17.64	$24.64	$38.36	$59.92	$91.84	$136.92
$150,000	$10.20	$12.00	$18.90	$26.40	$41.10	$64.20	$98.40	$146.70
$160,000	$10.88	$12.80	$20.16	$28.16	$43.84	$68.48	$104.96	$156.48
$170,000	$11.56	$13.60	$21.42	$29.92	$46.58	$72.76	$111.52	$166.26
$180,000	$12.24	$14.40	$22.68	$31.68	$49.32	$77.04	$118.08	$176.04
$190,000	$12.92	$15.20	$23.94	$33.44	$52.06	$81.32	$124.64	$185.82
$200,000	$13.60	$16.00	$25.20	$35.20	$54.80	$85.60	$131.20	$195.60
$210,000	$14.28	$16.80	$26.46	$36.96	$57.54	$89.88	$137.76	$205.38
$220,000	$14.96	$17.60	$27.72	$38.72	$60.28	$94.16	$144.32	$215.16
$230,000	$15.64	$18.40	$28.98	$40.48	$63.02	$98.44	$150.88	$224.94
$240,000	$16.32	$19.20	$30.24	$42.24	$65.76	$102.72	$157.44	$234.72
$250,000	$17.00	$20.00	$31.50	$44.00	$68.50	$107.00	$164.00	$244.50
$260,000	$17.68	$20.80	$32.76	$45.76	$71.24	$111.28	$170.56	$254.28
$270,000	$18.36	$21.60	$34.02	$47.52	$73.98	$115.56	$177.12	$264.06

	Employee's Age*							
	<35	35 -39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
Coverage								
$280,000	$19.04	$22.40	$35.28	$49.28	$76.72	$119.84	$183.68	$273.84
$290,000	$19.72	$23.20	$36.54	$51.04	$79.46	$124.12	$190.24	$283.62
$300,000	$20.40	$24.00	$37.80	$52.80	$82.20	$128.40	$196.80	$293.40
$310,000	$21.08	$24.80	$39.06	$54.56	$84.94	$132.68	$203.36	$303.18
$320,000	$21.76	$25.60	$40.32	$56.32	$87.68	$136.96	$209.92	$312.96
$330,000	$22.44	$26.40	$41.58	$58.08	$90.42	$141.24	$216.48	$322.74
$340,000	$23.12	$27.20	$42.84	$59.84	$93.16	$145.52	$223.04	$332.52
$350,000	$23.80	$28.00	$44.10	$61.60	$95.90	$149.80	$229.60	$342.30
$360,000	$24.48	$28.80	$45.36	$63.36	$98.64	$154.08	$236.16	$352.08
$370,000	$25.16	$29.60	$46.62	$65.12	$101.38	$158.36	$242.72	$361.86
$380,000	$25.84	$30.40	$47.88	$66.88	$104.12	$162.64	$249.28	$371.64
$390,000	$26.52	$31.20	$49.14	$68.64	$106.86	$166.92	$255.84	$381.42
$400,000	$27.20	$32.00	$50.40	$70.40	$109.60	$171.20	$262.40	$391.20
$410,000	$27.88	$32.80	$51.66	$72.16	$112.34	$175.48	$268.96	$400.98
$420,000	$28.56	$33.60	$52.92	$73.92	$115.08	$179.76	$275.52	$410.76
$430,000	$29.24	$34.40	$54.18	$75.68	$117.82	$184.04	$282.08	$420.54
$440,000	$29.92	$35.20	$55.44	$77.44	$120.56	$188.32	$288.64	$430.32
$450,000	$30.60	$36.00	$56.70	$79.20	$123.30	$192.60	$295.20	$440.10
$460,000	$31.28	$36.80	$57.96	$80.96	$126.04	$196.88	$301.76	$449.88
$470,000	$31.96	$37.60	$59.22	$82.72	$128.78	$201.16	$308.32	$459.66
$480,000	$32.64	$38.40	$60.48	$84.48	$131.52	$205.44	$314.88	$469.44
$490,000	$33.32	$39.20	$61.74	$86.24	$134.26	$209.72	$321.44	$479.22
$500,000	$34.00	$40.00	$63.00	$88.00	$137.00	$214.00	$328.00	$489.00

** Premiums for the spouse's coverage will be based on the employee's age. Spouse coverage cannot exceed 50% of the employee's Optional Life coverage or $100,000, whichever is less.*

Monthly Rates for Employees age 70 and Older

Coverage	Coverage	Ages 70 - 74	Coverage	Ages 75 - 79	Coverage	Ages 80+
$10,000	**$6,500**	$10.28	**$4,200**	$10.80	**$3,170**	$13.62
$20,000	**$13,000**	$20.54	**$8,400**	$21.60	**$6,340**	$27.26
$30,000	**$19,500**	$30.80	**$12,600**	$32.40	**$9,510**	$40.90
$40,000	**$26,000**	$41.08	**$16,800**	$43.20	**$12,680**	$54.52
$50,000	**$32,500**	$51.36	**$21,000**	$54.00	**$15,850**	$68.16
$60,000	**$39,000**	$61.62	**$25,200**	$64.80	**$19,020**	$81.80
$70,000	**$45,500**	$71.90	**$29,400**	$75.62	**$22,190**	$95.42
$80,000	**$52,000**	$82.16	**$33,600**	$86.42	**$25,360**	$109.06
$90,000	**$58,500**	$92.42	**$37,800**	$97.22	**$28,530**	$122.68
$100,000	**$65,000**	$102.70	**$42,000**	$108.02	**$31,700**	$136.30
$110,000	**$71,500**	$112.98	**$46,200**	$118.80	**$34,870**	$149.94
$120,000	**$78,000**	$123.24	**$50,400**	$129.62	**$38,040**	$163.58
$130,000	**$84,500**	$133.50	**$54,600**	$140.42	**$41,210**	$177.20
$140,000	**$91,000**	$143.78	**$58,800**	$151.22	**$44,380**	$190.82
$150,000	**$97,500**	$154.10	**$63,000**	$162.04	**$47,550**	$204.48
$160,000	**$104,000**	$164.32	**$67,200**	$172.84	**$50,720**	$218.10
$170,000	**$110,500**	$174.60	**$71,400**	$183.64	**$53,890**	$231.72

Coverage	Coverage	Ages 70-74	Coverage	Ages 75-79	Coverage	Ages 80+
$180,000	**$117,000**	$184.86	**$75,600**	$194.44	**$57,060**	$245.36
$190,000	**$123,500**	$195.12	**$79,800**	$205.26	**$60,230**	$259.00
$200,000	**$130,000**	$205.40	**$84,000**	$216.06	**$63,400**	$272.62
$210,000	**$136,500**	$215.68	**$88,200**	$226.86	**$66,570**	$286.26
$220,000	**$143,000**	$225.94	**$92,400**	$237.66	**$69,740**	$299.88
$230,000	**$149,500**	$236.20	**$96,600**	$248.46	**$72,910**	$313.50
$240,000	**$156,000**	$246.48	**$100,800**	$259.26	**$76,080**	$327.14
$250,000	**$162,500**	$256.76	**$105,000**	$270.06	**$79,250**	$340.78
$260,000	**$169,000**	$267.16	**$109,200**	$280.86	**$82,420**	$354.40
$270,000	**$175,500**	$277.30	**$113,400**	$291.66	**$85,590**	$368.04
$280,000	**$182,000**	$287.56	**$117,600**	$302.48	**$88,760**	$381.68
$290,000	**$188,500**	$297.82	**$121,800**	$313.28	**$91,930**	$395.30
$300,000	**$195,000**	$308.10	**$126,000**	$324.08	**$95,100**	$408.92
$310,000	**$201,500**	$318.36	**$130,200**	$334.88	**$98,270**	$422.56
$320,000	**$208,000**	$328.64	**$134,400**	$345.68	**$101,440**	$436.20
$330,000	**$214,500**	$338.90	**$138,600**	$356.48	**$104,610**	$449.82
$340,000	**$221,000**	$349.18	**$142,800**	$367.28	**$107,780**	$463.46
$350,000	**$227,500**	$359.46	**$147,000**	$378.08	**$110,950**	$477.10
$360,000	**$234,000**	$369.72	**$151,200**	$388.90	**$114,120**	$490.72
$370,000	**$240,500**	$380.00	**$155,400**	$399.70	**$117,290**	$504.36
$380,000	**$247,000**	$390.26	**$159,600**	$410.50	**$120,460**	$517.98
$390,000	**$253,500**	$400.54	**$163,800**	$421.30	**$123,630**	$531.60
$400,000	**$260,000**	$410.80	**$168,000**	$432.10	**$126,800**	$545.24
$410,000	**$266,500**	$421.08	**$172,200**	$442.90	**$129,970**	$558.88
$420,000	**$273,000**	$431.34	**$176,400**	$453.70	**$133,140**	$572.50
$430,000	**$279,500**	$441.60	**$180,600**	$464.50	**$136,310**	$586.12
$440,000	**$286,000**	$451.88	**$184,800**	$475.30	**$139,480**	$599.76
$450,000	**$292,500**	$462.16	**$189,000**	$486.10	**$142,650**	$613.40
$460,000	**$299,000**	$472.42	**$193,200**	$496.90	**$145,820**	$627.02
$470,000	**$305,500**	$482.70	**$197,400**	$507.70	**$148,990**	$640.66
$480,000	**$312,000**	$492.96	**$201,600**	$518.52	**$152,160**	$654.30
$490,000	**$318,500**	$503.22	**$205,800**	$529.32	**$155,330**	$667.92
$500,000	**$325,000**	$513.50	**$210,000**	$540.12	**$158,500**	$681.56

Dependent Life Child Monthly Premiums

Monthly premium for Dependent Life Child coverage is $1.24, regardless of the number of children covered.

2006 Long Term Care Monthly Premiums* - Option 1
(Disability Model)

2006 LONG TERM CARE RATES*							
OPTION 1 (Disability)							
Return of Contribution Excluded				Return of Contribution Included			
AGE	Per $10	AGE	Per $10	AGE	Per $10	AGE	Per $10
20	0.20	**60**	6.64	**20**	0.22	**60**	7.20
21	0.24	**61**	7.18	**21**	0.24	**61**	7.72
22	0.26	**62**	7.76	**22**	0.26	**62**	8.28
23	0.28	**63**	8.38	**23**	0.28	**63**	8.90
24	0.30	**64**	9.08	**24**	0.32	**64**	9.56
25	0.34	**65**	9.84	**25**	0.36	**65**	10.26
26	0.38	**66**	10.66	**26**	0.40	**66**	11.16
27	0.40	**67**	11.54	**27**	0.42	**67**	12.16
28	0.44	**68**	12.52	**28**	0.46	**68**	13.28
29	0.48	**69**	13.56	**29**	0.52	**69**	14.48
30	0.54	**70**	14.72	**30**	0.56	**70**	15.84
31	0.58	**71**	15.98	**31**	0.62	**71**	17.34
32	0.62	**72**	17.32	**32**	0.68	**72**	19.00
33	0.70	**73**	18.80	**33**	0.74	**73**	20.82
34	0.76	**74**	20.38	**34**	0.82	**74**	22.88
35	0.82	**75**	22.16	**35**	0.90	**75**	25.14
36	0.90	**76**	24.08	**36**	0.98	**76**	27.68
37	0.98	**77**	26.12	**37**	1.08	**77**	30.46
38	1.08	**78**	28.30	**38**	1.18	**78**	33.50
39	1.18	**79**	30.44	**39**	1.30	**79**	36.60
40	1.30	**80**	32.52	**40**	1.42	**80**	39.76
41	1.40	**81**	34.44	**41**	1.56	**81**	42.84
42	1.54	**82**	36.14	**42**	1.72	**82**	45.82
43	1.68	**83**	37.60	**43**	1.88	**83**	48.60
44	1.84	**84**	38.92	**44**	2.06	**84**	51.30
45	2.00	**85**	40.12	**45**	2.24	**85**	53.92
46	2.18	**86**	41.20	**46**	2.44	**86**	56.46
47	2.36	**87**	42.18	**47**	2.64	**87**	58.92
48	2.56	**88**	43.02	**48**	2.88	**88**	61.32
49	2.78	**89**	43.84	**49**	3.10	**89**	63.80
50	3.02	**90+**	44.66	**50**	3.36	**90+**	66.46
51	3.24			**51**	3.66		
52	3.52			**52**	3.94		
53	3.82			**53**	4.26		
54	4.14			**54**	4.62		
55	4.48			**55**	4.98		
56	4.84			**56**	5.38		
57	5.26			**57**	5.80		
58	5.68			**58**	6.24		
59	6.14			**59**	6.70		

* *Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.*

2006 Long Term Care Monthly Premiums* - Option 2
(Service Reimbursement - 50% Home Health)

2006 LONG TERM CARE RATES*							
OPTION 2 (Service Reimbursement)**							
Return of Contribution Excluded				Return of Contribution Included			
AGE	Per $10	AGE	Per $10	AGE	Per $10	AGE	Per $10
20	0.28	**60**	5.02	**20**	0.28	**60**	5.14
21	0.28	**61**	5.52	**21**	0.30	**61**	5.66
22	0.30	**62**	6.06	**22**	0.32	**62**	6.22
23	0.34	**63**	6.70	**23**	0.34	**63**	6.86
24	0.36	**64**	7.40	**24**	0.36	**64**	7.54
25	0.38	**65**	8.06	**25**	0.38	**65**	8.22
26	0.40	**66**	8.90	**26**	0.42	**66**	9.10
27	0.44	**67**	9.90	**27**	0.46	**67**	10.16
28	0.48	**68**	10.70	**28**	0.50	**68**	11.00
29	0.54	**69**	11.60	**29**	0.56	**69**	11.96
30	0.58	**70**	12.62	**30**	0.58	**70**	13.04
31	0.62	**71**	13.76	**31**	0.64	**71**	14.28
32	0.68	**72**	15.04	**32**	0.70	**72**	15.68
33	0.72	**73**	16.44	**33**	0.74	**73**	17.26
34	0.78	**74**	18.02	**34**	0.80	**74**	19.06
35	0.84	**75**	19.78	**35**	0.88	**75**	21.08
36	0.90	**76**	21.74	**36**	0.92	**76**	23.38
37	0.98	**77**	23.94	**37**	1.00	**77**	26.04
38	1.04	**78**	26.34	**38**	1.06	**78**	29.00
39	1.10	**79**	28.92	**39**	1.14	**79**	32.26
40	1.18	**80**	31.48	**40**	1.20	**80**	35.62
41	1.24	**81**	33.80	**41**	1.28	**81**	38.80
42	1.32	**82**	36.02	**42**	1.36	**82**	42.00
43	1.40	**83**	38.44	**43**	1.46	**83**	45.60
44	1.48	**84**	40.60	**44**	1.54	**84**	49.14
45	1.58	**85**	42.46	**45**	1.66	**85**	52.48
46	1.68	**86**	44.54	**46**	1.74	**86**	56.34
47	1.78	**87**	46.30	**47**	1.84	**87**	60.02
48	1.90	**88**	47.74	**48**	1.98	**88**	63.56
49	2.04	**89**	48.94	**49**	2.12	**89**	66.96
50	2.16	**90+**	49.70	**50**	2.26	**90+**	69.80
51	2.32			**51**	2.40		
52	2.46			**52**	2.58		
53	2.70			**53**	2.80		
54	2.94			**54**	3.04		
55	3.20			**55**	3.30		
56	3.48			**56**	3.62		
57	3.82			**57**	3.94		
58	4.16			**58**	4.32		
59	4.58			**59**	4.72		

** Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.*

***Includes 50 percent home healthcare benefit payout.*

2006 Long Term Care Monthly Premiums* - Option 3
(Service Reimbursement - 100% Home Health)

2006 LONG TERM CARE RATES*							
OPTION 3 (Service Reimbursement)**							
Return of Contribution Excluded				Return of Contribution Included			
AGE	Per $10	AGE	Per $10	AGE	Per $10	AGE	Per $10
20	0.42	**60**	6.90	**20**	0.42	**60**	7.06
21	0.44	**61**	7.56	**21**	0.44	**61**	7.76
22	0.46	**62**	8.32	**22**	0.46	**62**	8.48
23	0.48	**63**	9.18	**23**	0.50	**63**	9.34
24	0.52	**64**	10.14	**24**	0.52	**64**	10.30
25	0.56	**65**	11.00	**25**	0.58	**65**	11.18
26	0.60	**66**	12.14	**26**	0.62	**66**	12.36
27	0.66	**67**	13.48	**27**	0.68	**67**	13.76
28	0.72	**68**	14.58	**28**	0.72	**68**	14.90
29	0.78	**69**	15.78	**29**	0.80	**69**	16.20
30	0.84	**70**	17.14	**30**	0.86	**70**	17.62
31	0.90	**71**	18.66	**31**	0.92	**71**	19.26
32	0.98	**72**	20.34	**32**	1.00	**72**	21.08
33	1.06	**73**	22.20	**33**	1.10	**73**	23.16
34	1.14	**74**	24.30	**34**	1.18	**74**	25.50
35	1.24	**75**	26.56	**35**	1.28	**75**	28.14
36	1.32	**76**	29.18	**36**	1.36	**76**	31.18
37	1.40	**77**	32.06	**37**	1.44	**77**	34.62
38	1.48	**78**	35.20	**38**	1.54	**78**	38.48
39	1.60	**79**	38.56	**39**	1.66	**79**	42.70
40	1.70	**80**	41.88	**40**	1.76	**80**	47.04
41	1.82	**81**	44.92	**41**	1.88	**81**	51.18
42	1.92	**82**	47.84	**42**	1.98	**82**	55.34
43	2.04	**83**	50.94	**43**	2.10	**83**	59.98
44	2.14	**84**	53.70	**44**	2.22	**84**	64.42
45	2.28	**85**	55.90	**45**	2.34	**85**	68.50
46	2.40	**86**	58.56	**46**	2.48	**86**	73.40
47	2.54	**87**	60.78	**47**	2.62	**87**	78.10
48	2.70	**88**	62.62	**48**	2.80	**88**	82.62
49	2.90	**89**	64.22	**49**	2.98	**89**	87.00
50	3.08	**90+**	65.14	**50**	3.18	**90+**	90.64
51	3.26			**51**	3.38		
52	3.48			**52**	3.60		
53	3.80			**53**	3.92		
54	4.10			**54**	4.24		
55	4.46			**55**	4.62		
56	4.86			**56**	5.02		
57	5.30			**57**	5.46		
58	5.78			**58**	5.94		
59	6.32			**59**	6.48		

** Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.*

***Includes 100 percent home healthcare benefit payout.*

2006 Monthly Insurance Rates for Part-time Teachers

Health

Category I. 15-19 Hours								
COVERAGE LEVEL	**Savings**	**Standard**	**BlueChoice HealthPlan**	**CIGNA**	**MUSC Options**	**Employer**	**Employee TRICARE Supplement**	**Employee TRICARE Supplement**
Employee only	$125.20	$209.38	$241.22	$242.92	$235.16	$115.92	$0.00	$ 63.50
Employee/spouse	$299.08	$464.02	$592.24	$591.70	$561.90	$226.52	$0.00	$122.50
Employee/children	$183.88	$306.06	$432.06	$430.72	$387.16	$163.60	$0.00	$122.50
Full family	$373.06	$559.08	$804.68	$801.48	$696.32	$264.50	$0.00	$163.50

Category II. 20-24 Hours								
COVERAGE LEVEL	**Savings**	**Standard**	**BlueChoice HealthPlan**	**CIGNA**	**MUSC Options**	**Employer**	**Employee TRICARE Supplement**	**Employee TRICARE Supplement**
Employee only	$ 85.80	$169.98	$201.82	$203.52	$195.76	$155.34	$0.00	$ 63.50
Employee/spouse	$222.06	$387.00	$515.22	$514.68	$484.88	$303.52	$0.00	$122.50
Employee/children	$128.26	$250.44	$376.44	$375.10	$331.54	$219.22	$0.00	$122.50
Full family	$283.14	$469.16	$714.76	$711.56	$606.40	$354.44	$0.00	$163.50

Category III. 25-29 Hours								
COVERAGE LEVEL	**Savings**	**Standard**	**BlueChoice HealthPlan**	**CIGNA**	**MUSC Options**	**Employer**	**Employee TRICARE Supplement**	**Employee TRICARE Supplement**
Employee only	$ 48.70	$132.88	$164.72	$166.42	$158.66	$192.44	$0.00	$ 63.50
Employee/spouse	$149.58	$314.52	$442.74	$442.20	$412.40	$376.02	$0.00	$122.50
Employee/children	$ 75.90	$198.08	$324.08	$322.74	$279.18	$271.56	$0.00	$122.50
Full family	$198.50	$384.52	$630.12	$626.92	$521.76	$439.08	$0.00	$163.50

Dental

COVERAGE LEVEL	**Category I. 15-19 Hours**			**Category II. 20-24 Hours**			**Category III. 25-29 Hours**		
	Employee	**Employer**	**Dental Plus**	**Employee**	**Employer**	**Dental Plus**	**Employee**	**Employer**	**Dental Plus**
Employee	$ 5.86	$5.85	$18.52	$ 3.86	$7.85	$18.52	$ 2.00	$9.71	$18.52
Employee/spouse	$13.50	$5.85	$35.06	$ 11.50	$7.85	$35.06	$ 9.64	$9.71	$35.06
Employee/children	$19.58	$5.85	$38.26	$17.58	$7.85	$38.26	$15.72	$9.71	$38.26
Full family	$27.20	$5.85	$54.80	$25.20	$7.85	$54.80	$23.34	$9.71	$54.80

Glossary

Actively at Work

An employee is considered actively at work on an employer's scheduled workday if he is performing in the usual manner all of the regular duties of his work on a full-time basis on that day. He may be doing so at his usual work place or at another place if required to travel. An employee is considered actively at work on a paid vacation day or on a day that is not one of the employer's scheduled workdays, only if he was actively at work on the preceding scheduled workday.

Allowable Charge

The maximum amount a health plan (such as the State Health Plan, an HMO or Medicare) will pay for a covered service or for a product, such as a drug. Network providers have agreed to accept the allowable charge. An "actual charge" is the provider's full price for a covered service or a product before any negotiated discounts are applied.

Annual Enrollment

A period during which eligible subscribers may change health plans only (SHP Savings to Standard, Standard to Savings, SHP to an HMO, HMO to SHP or HMO to another HMO). The only other health plan changes allowed are changing to or from the TRICARE Supplement. Eligible subscribers may only change to or from the Medicare Supplemental Plan within 31 days of eligibility or during open enrollment, which occurs in October of odd-numbered years. The Medicare Supplemental Plan is not offered to active subscribers. See also *Open Enrollment*.

Basic Salary

The actual amount an employee is paid by the employer each year, including merit and longevity increases. Basic salary does not include commissions, annuities, bonuses, overtime or incentive pay. For a teacher, basic salary does not include compensation for summer school.

Child

See *Dependent Child*.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985. This act requires that continuation of group insurance coverage be offered to covered persons who lose health or dental coverage due to a qualifying event as defined in the act. See also *Qualifying Event*.

Coinsurance

Coinsurance is the percentage of covered medical expenses a subscriber must pay in conjunction with the percentage paid by an insurance plan. These amounts are called coinsurance because the subscriber and the insurance plan share the cost of healthcare.

Coinsurance Maximum

The coinsurance maximum is the most money a subscriber would pay in coinsurance each year, not including copayments and deductibles, before an insurance plan begins to pay 100 percent of the allowable charge for covered expenses. This does not apply to the Medicare Supplemental Plan.

Coordination of Benefits

A system to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits paid under the two plans may not exceed 100 percent of the claim.

Copayment

A copayment is a fixed dollar amount a subscriber must pay for covered expenses in addition to what is paid by an insurance plan. These amounts are called copayments because the subscriber and the insurance plan share the cost of healthcare.

Copayment Maximum

The most money in copayments a subscriber would pay each year before an insurance plan begins to pay the entire allowable charge for covered expenses.

Covered Dental Expense

An expense that is provided for, and deemed medically necessary by, the plan, up to the maximum amount listed in the Schedule of Dental Procedures and Allowable Charges (fee schedule), and is not excluded by any term, condition, limitation or exclusion of the plan. See also *Dental Schedule of Procedures and Allowable Charges*.

Covered Medical Expense

A medical expense that is considered medically necessary and is not excluded by any term, condition, limitation or exclusion of the plan. See also *Medically Necessary.*

Covered Person

A person (employee, retiree, survivor, COBRA participant or dependent), who has met the eligibility requirements, and is enrolled in an insurance plan. See also *Subscriber*.

Creditable Coverage

Prior coverage under a group health plan or insurance coverage or health benefits described or defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proof of creditable coverage (a form from your previous insurance company, listing your dates of coverage) may be used to reduce a pre-existing condition limitation period, provided the coverage was continuous (any break in coverage did not exceed 62 days). See also *Pre-existing Condition.*

Deductible

The amount a subscriber must pay each year, if it is an annual deductible, or each time a service is received, if it is a per-occurrence deductible, toward covered expenses before the insurance plan begins to pay benefits.

Deferred Effective Date

A delay in the date insurance coverage starts. It may apply to an employee who is absent from work due to an injury or sickness on the date coverage would have begun. The date coverage starts is then postponed until the individual returns to work as an active, permanent, full-time employee for one full day. See also *Actively at Work*.

Dental Course of Treatment

All treatment performed in the mouth during one or more sessions as the result of the same diagnosis. Treatment includes examination, X-rays, prophylaxis and any complications arising from such treatment. Note: Some surgical procedures may be covered by a subscriber's health plan.

Dental Schedule of Procedures and Allowable Charges

The list of dental procedures covered by the State Dental Plan and the amount the plan will pay for each procedure.

Dependent Child

An unmarried child, under 19 years of age (or under age 25 if a full-time student), and who is principally dependent (more than 50 percent) upon the subscriber for maintenance and support. The child must be: (1) the natural or adopted child, stepchild, foster child or child for whom the subscriber has legal custody and who resides in the subscriber's home in a parent-child relationship; or (2) for whom the subscriber provides support and maintenance due to a court order. See also *Foster Child, Full-time Student* and *Incapacitated Child*.

Dependent Spouse

A lawful spouse of a subscriber, or a former spouse who is required to be covered by a divorce decree or court order, but not both spouses. If a spouse is also eligible for coverage or benefits as an employee of a participating employer, the spouse may not be covered as a dependent. However, a part-time teacher, who is the spouse of a covered employee, may be covered as an employee or as a dependent, but not as both.

Eligible Employee

- Is employed by the state, a school district or a participating local subdivision
- Is in a permanent full-time position as defined by the plan
- Receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipal councils who also participate in the S.C. Retirement Systems (SCRS) are considered employees for insurance purposes. If you work for more than one participating employer, please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu$ and vision care benefits.

Enrollment Date

(1) The hire date for an employee; (2) the effective date of coverage for an individual who enrolls under a special eligibility situation and for a late entrant; and (3) the retirement date for a retiree.

Exclusion

A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

Extended Care Benefits

Benefits that provide for medical care in a more cost-effective setting when hospitalization is not required or necessary. Extended care benefits include home healthcare, skilled nursing facility care, hospice care and alternative treatment plans.

Foster Child

A child who is placed with the employee by an authorized placement agency and who is cared for by the employee as if the child were his own child.

Funded Retiree

A funded retiree is one who is eligible for an employer contribution to his or her retiree insurance premiums.

Full-time Student

An unmarried person, who is over 19 years of age but less than 25 years old, who is enrolled in and attending a high school; a trade, vocational or technical school; or a college or university on a full-time basis, as defined by the institution. Correspondence courses do not count toward eligibility as a full-time student.

Under the TRICARE Supplement, eligibility for coverage as a full-time student ends at age 23.

Health Maintenance Organization (HMO)

A managed care plan that has contracts with healthcare providers (doctors, hospitals, etc.) that form a provider network. HMO subscribers are required to see only providers within this network. If a subscriber receives care outside of the network, the HMO will not pay benefits for these services unless the care was pre-authorized or deemed an emergency. A subscriber chooses a primary care physician (PCP) who coordinates all aspects of his healthcare. To receive benefits, a subscriber must receive a referral from his PCP before he can see a specialist.

Home Healthcare

Part-time nursing care; health aide service; or physical, occupational or speech therapy provided by an approved home healthcare agency and given in the subscriber's home. These services do not include custodial care or care given by a person who ordinarily lives in the home or a member of the subscriber's family or of the spouse's family.

Hospital

A legally designated and operated institution caring for the sick, such as a general hospital; children's hospital; eye, ear, nose and throat hospital; maternity hospital or an ambulatory surgical center. "Hospital" also includes a legally constituted and operational psychiatric facility for the treatment of mental or nervous conditions or substance abuse. Hospitals must provide inpatient care given by, or supervised by, a staff of licensed physicians and must provide continuous, 24-hour services by licensed registered nurses who are physically present and on duty. Nursing homes, rest homes, homes for the aged and convalescent homes are typically not considered hospitals under insurance plans, whether or not they are affiliated with a hospital.

Identification Number

Under most plans, the covered person's Social Security Number is his identification number. Identification cards are issued by the insurance plan. Note for retirees: Under the State Health Plan Savings, Standard or Medicare Supplemental plan, the retiree's Social Security Number is used by all covered family members. Use the number listed on the Medicare card for Medicare claims and information. Note for survivors: For surviving spouses and surviving spouses with covered children, the surviving spouse's Social Security Number is used for all covered family members. For surviving children only, the youngest child's Social Security Number is used.

Incapacitated Child

An unmarried child who is incapable of self-sustaining employment because of mental illness or physical disability, and who is principally dependent (more than 50 percent) on the subscriber for maintenance and support. Incapacitation must have begun before age 19 or while an eligible, covered dependent was a full-time student. If eligible but not previously covered, the child may not be added until the next open enrollment period (or within 31 days of a special eligibility situation), and coverage is subject to pre-existing condition limitations.

Incurred Expense

An expense is considered incurred on the date services were provided or supplies were received.

Injury

Accidental damage to the body that requires treatment by a physician. Any loss that results from the injury must be independent of sickness or other causes.

Late Entrant

A full-time employee or eligible retiree, and any eligible dependent of that employee or retiree, who is not enrolled within 31 days of that person's first date of eligibility and who later enrolls during an open enrollment period. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage begins.

Local Subdivision

Any participating employer covered by local jurisdiction rather than state. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. To be eligible to participate in the state insurance benefits program, a public employer in South Carolina must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

Medi-Call

Medi-Call reviews subscribers' use of the State Health Plan and must pre-authorize some benefits provided by the plan. Medi-Call helps subscribers receive appropriate medical care in the most beneficial, cost-effective manner. Note: Retirees and dependents entitled to Medicare must call Medi-Call for home healthcare, hospice, durable medical equipment, Veterans Administration hospital services and when a hospital stay exceeds the number of days allowed by Medicare. For details, see page 13.

Medically Necessary

Services or supplies ordered by a physician or behavioral healthcare provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice in the medical specialty or field when the patient receives the service and must be in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and must be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Mental Health and Substance Abuse Provider

A physician, psychiatrist, health professional or institution that is part of the provider network administered by the APS Healthcare, Inc.

Non-funded Retiree

A non-funded retiree is a retiree who does not qualify for an employer contribution to the cost of his insurance and who must pay the full premium.

Non-preferred Brand Drug

A medication that is not on the preferred brand list and, therefore, carries a higher copayment than a generic or preferred brand drug. There is an effective alternative, either as a generic or as a preferred brand

drug, for all medications on the non-preferred brand list.

Notice of Election Form

The Notice of Election (NOE) form is the application form used to enroll in benefits; add or delete dependents; or change a subscriber's coverage level, beneficiary, name or address.

Open Enrollment

A period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan without regard to any special eligibility situations. Retirees may also change to and from the Medicare Supplemental Plan. Open enrollment is held in odd-numbered years during October, and changes become effective the following January 1.

Optional Employer

See *Local Subdivision.*

Out-of-Network Differential

If you choose to go to a healthcare provider that does not participate in a State Health Plan network, you will be responsible for a higher coinsurance percentage of your covered medical expenses, and you may be billed the difference between the allowed and actual charge. This out-of-network differential applies to all State Health Plan networks except the Mental Health and Substance Abuse and Pharmacy networks, where no out-of-network benefits are provided.

Out-of-pocket Maximum

The most money a covered person will be required to pay a year in deductibles, copayments and coinsurance. The amounts are set by each insurance plan.

Part-time Teacher

A teacher, who is in a permanent position, and who works at least 15 hours, but no more than 29 hours, a week at a South Carolina public school, the S.C. Department of Juvenile Justice or the S.C. Department of Corrections. He must also be in a contract position and receive an Education Improvement Act (EIA) salary supplement. A part-time teacher is eligible for state health, dental, Dental Plus, MoneyPlu$ and Vision Care benefits. Premiums are determined by the number of hours an eligible part-time teacher works each week.

Participating Employer

A state agency, public school district, county, municipality or other group participating in the plan.

"Pay-the-Difference" Policy

Under the State Health Plan, if a generic drug is available and a subscriber chooses to purchase or his doctor prescribes the brand name medication instead, the benefit will be limited to the amount payable for the generic medication. The subscriber will be responsible for paying the difference in the benefit between the brand name drug and the generic drug, plus the generic copayment. The difference does not apply to the subscriber's annual copayment maximum.

Per-occurrence Deductible

The amount a covered person must pay each time he visits a physician's office or receives an emergency room, inpatient or outpatient hospital service before the health plan begins to pay benefits.

Physician

A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, psychiatrist or licensed counseling or clinical psychologist.

Plan Year

January 1 through December 31.

Point of Service (POS)

A managed care plan that allows a subscriber to choose providers or specialists within the plan's network as referred by his primary care physician, or subscribers can self-refer to a provider outside the network. If a subscriber uses out-of-network services, benefits are paid at a reduced level.

Pre-existing Condition

Any medical condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed healthcare provider or practitioner in the six months before the covered person's enrollment date. Benefits will not be paid for a pre-existing condition for the first 12 months (18 months for a late entrant) after enrollment. Pregnancy does not constitute a pre-existing condition. See also *Creditable Coverage*.

Preferred Brand Drugs

Medications that have been determined safe, effective and available at a lower cost by Medco's Pharmacy and Therapeutics Committee. A list of preferred brand medications is available at www.medco.com.

Preferred Provider Organization (PPO)

A PPO is a type of health or dental plan that is similar to a fee-for-service plan. A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you.

Premium

The amount a covered person pays for insurance coverage.

Prescription Drug

Any drug or medicine required to bear the following wording, "Caution: Federal law prohibits dispensing without prescription." Insulin or drugs licensed or accepted for a specific diagnosis as listed in the U.S. Pharmacopoeia Publication, Drug Information for Health Care Professionals, are also considered prescription drugs. Drugs in FDA phase I, II or III testing are not covered.

Primary Care Physician/Doctor

Usually the first contact for healthcare. This is often a family physician, internist, pediatrician, or in some cases, a gynecologist. A primary care physician monitors the patient's health, diagnoses and treats minor health problems and refers the patient to specialists if another level of care is necessary.

Private Duty Nursing Services

Private services of a registered nurse or licensed practical nurse. Services must be certified in writing by a physician as medically necessary.

Provider

Any person (i.e., doctor, nurse, dentist) or facility (i.e., hospital or clinic) that provides healthcare, acting within the scope of his/its license.

Qualifying Event

An event that causes a loss of health and/or dental insurance and allows an extension of coverage for an employee, a spouse or a dependent. Such events include loss of a job, a reduction in hours that makes an employee ineligible for coverage, death, divorce or legal separation, loss of a dependent's eligibility for coverage, eligibility for Medicare by a covered employee or a parent of an eligible dependent child. See also *COBRA*.

Self-insured Plan

A self-insured insurance plan is one in which an employer or group of employers assume direct financial responsibility for the costs of health claims. Employers sponsoring self-insured plans typically contract with an insurance carrier or third party claims processor to provide administrative services for the self-insured plan.

Significant Break in Coverage

Used to apply a pre-existing condition limitation, a period of 63 or more consecutive days during which an individual does not have creditable insurance coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. See also *Creditable Coverage*.

Skilled Care

Services provided according to a physician's order, given by or under the direction of a qualified technical or professional healthcare provider. Healthcare providers include registered nurses, licensed practical nurses, physical therapists, speech pathologists and audiologists.

Special Eligibility Situation

A qualifying event that allows eligible employees, retirees, survivors or COBRA subscribers to enroll themselves and/or their eligible dependents in an insurance plan. Examples include: marriage, birth, adoption or placement for adoption. Involuntary loss of other coverage applies only to those who lost coverage. Enrollment changes must be requested within 31 days of the qualifying event. Note: A salary increase does not constitute a special eligibility situation. See also *Qualifying Event*.

Specialty Drugs/Pharmaceuticals

A pharmaceutical product that is generally, but not exclusively, biotechnological in nature. Biotechnological drugs are those manufactured using a live substance rather than a chemical reaction. These high-cost medications are typically used to treat serious conditions.

Spouse

See *Dependent Spouse*.

State Health Plan (SHP)

The term used generally to identify the Savings, Standard, and Medicare Supplemental plans.

Subscriber

An active or retired employee, survivor or COBRA subscriber of a state agency, public school district, participating county or other eligible employer, and his dependents who are enrolled in a benefits plan. See also *Covered Person*.

TERI

Teacher and Employee Retention Incentive program of the S.C. Retirement Systems.

Transfer/Transferring Employee

An active employee is considered a transferring employee if he moves from one state group employer to another with no more than a 15-calendar-day break in employment or no break in insurance coverage. An academic employee who completes a school term and moves to another academic setting at the beginning of the next school term is also considered a transferring employee. A transferring employee is not considered a new hire for insurance program purposes.

You

Any person who is insured under the policy. You and/or your covered dependents.

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SOCIAL SECURITY ADMINISTRATION

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800-325-0778 (TTY)
www.ssa.gov
www.socialsecurity.gov

THE STANDARD INSURANCE COMPANY

Basic Long Term Disability, Supplemental Long Term Disability

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Portland, OR 97208

General Information and Claims: 800-628-9696
Fax: 800-437-0961
Medical Evidence: 800-843-7979
www.standard.com

MY PERSONAL HEALTHCARE CONTACTS

Doctors:_____

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Dentists:_____

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Pharmacies:_____

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Hospitals:_____

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Other:_____

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South Carolina Budget and Control Board
Employee Insurance Program
Post Office Box 11661
Columbia, South Carolina 29211
803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside Columbia area)
Web: www.eip.sc.gov
E-mail: cs@eip.sc.gov